provisions of E.O. 12291. Accordingly, this action is not subject to those provisions of E.O. 12778 which are contingent upon review by OMB. Nevertheless, the Deputy Assistant Administrator has determined that this is not a "major rule," as that term is used in E.O. 12291, and that it would otherwise meet the applicable standards of sections 2(a) and 2(b)(2) of E.O. 12778.

List of Subjects in 21 CFR Part 1308

Administrative practice and procedure, Drug traffic control, Narcotics, Prescription drugs.

Under the authority vested in the Attorney General by title XIX of Public Law 101-647, as delegated to the Administrator of the DEA pursuant to 21 U.S.C. 871(a) and 28 CFR 0.100, and redelegated to the Deputy Assistant Administrator, Office of Diversion Control in 28 CFR 0.104, appendix to subpart R, section 7(g), the Deputy Assistant Administrator of the Office of Diversion Control hereby adopts as a final rule, the interim rule amending 21 CFR 1308.34 which was published at 57 FR 32423 on July 22, 1992, with the following changes:

PART 1308—SCHEDULES OF CONTROLLED SUBSTANCES

1. The authority citation for 21 CFR part 1308 continues to read as follows:

Authority: 21 U.S.C. 811, 812, 871(b), unless otherwise noted.

2. In § 1308.34 the table is revised to read as follows:

§ 1308.34 Exempt anabolic steroid products.

TABLE OF EXEMPT ANABOLIC STEROID PRODUCTS

Trade name	Company	NDC No.	Form	Ingredients	Quantity
Androgyn L.A.	Forest Pharmaceuticals, St. Louis, MO	0456-1005	Vial	Testosterone enanthate	90 mg/ml
				Estradiol valerate	4 mg/ml
Andro-Estro 90-4	Rugby Laboratories, Rockville Centre, NY	0536-1605	Vial	Testosterone enanthate	90 mg/ml
				Estradiol valerate	4 mg/ml
depANDROGYN	Forest Pharmaceuticals, St. Louis, MO	0456-1020	Vial	Testosterone cypionate	50 mg/ml
				Estradiol cypionate	2 mg/ml
DEPO-T.E.	Quality Research Pharm., Carmel, IN	52765-257	Vial	Testosterone cypionate	50 mg/ml
				Estradiol cypionate	2 mg/ml
depTESTROGEN	Martica Pharmaceuticals, Phoenix, AZ	51698-257	Vial	Testosterone cypionate	50 mg/ml
				Estradiol cypionate	2 mg/ml
Duomone	Wintec Pharmaceutical, Pacific, MO	52047-360	Vial	Testosterone enanthate	90 mg/ml
				Estradiol valerate	4 mg/ml
DURATESTRIN	W.E. Hauck, Alpharetta, GA	43797-016	Vial	Testosterone cypionate	50 mg/ml
				Estradiol cypionate	2 mg/ml
DUO-SPAN II	Primedics Laboratories, Gardena, CA	0684-0102	Vial	Testosterone cypionate	50 mg/ml
				Esterified cypionate	2 mg/ml
Estratest	Solvay Pharmaceuticals, Marletta, GA	0032-1026	TB	Esterified estrogens	1.25 mg
				Methyltestosterone	2.5 mg
Estratest HS	Solvay Pharmaceuticals, Marletta, GA	0032-1023	TB	Esterified estrogens	0.625 mg
				Methyltestosterone	1.25 mg
PAN ESTRA TEST	Pan American Labs, Covington, LA	0525-0175	Vial	Testosterone cypionate	50 mg/ml
				Estradiol cypionate	2 mg/ml
Premarin with Methyltestosterone	Ayerst Labs. Inc., New York, NY	0046-0879	TB	Conjugated estrogens	1.25 mg
				Methyltestosterone	10.0 mg
Premarin with Methyltestosterone	Ayerst Labs. Inc., New York, NY	0046-0878	TB	Conjugated estrogens	0.625 mg
				Methyltestosterone	5.0 mg
TEST-ESTRO Cypionates	Rugby Laboratories, Rockville Centre, NY	0536-9470	Vial	Testosterone cypionate	50 mg/ml
				Estradiol cypionate	2 mg/ml
Testosterone Cyp 50 Estradiol Cyp 2	I.D.E.-Interstate, Amityville, NY	0814-7737	Vial	Testosterone cypionate	50 mg/ml
				Estradiol cypionate	2 mg/ml
Testosterone Cypionate—Estradiol Cypionate Injection.	Best Generics, No. Miami Beach, FL	54274-530	Vial	Testosterone cypionate	50 mg/ml
				Estradiol cypionate	2 mg/ml
Testosterone Cypionate—Estradiol Cypionate Injection.	Schein Pharmaceuticals, Port Washington, NY.	0364-6611	Vial	Testosterone cypionate	50 mg/ml
				Estradiol cypionate	2 mg/ml
Testosterone Cypionate—Estradiol Cypionate Injection.	Steris Labs. Inc., Phoenix, AZ	0402-0257	Vial	Testosterone cypionate	50 mg/ml
				Estradiol cypionate	2 mg/ml
Testosterone Enanthate—Estradiol Valerate Injection.	Schein Pharmaceuticals, Port Washington, NY.	0364-6618	Vial	Testosterone enanthate	90 mg/ml
				Estradiol valerate	4 mg/ml
Testosterone Enanthate—Estradiol Valerate Injection.	Steris Labs. Inc., Phoenix, AZ	0402-0360	Vial	Testosterone enanthate	90 mg/ml
				Estradiol valerate	4 mg/ml

* * * * *

Dated: November 16, 1992.

Gene R. Haislip,

Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration.

[FR Doc. 92-28494 Filed 11-23-92; 8:45 am]

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OFFICE OF NATIONAL DRUG CONTROL POLICY

21 CFR Part 1403

Uniform Administrative Requirements for Grants and Cooperative Agreements

AGENCY: Office of National Drug Control Policy.

ACTION: Final rule.

SUMMARY: On March 12, 1987, President Reagan directed all affected agencies to issue a grants management common rule (the "Common Rule") to adopt government-wide terms and conditions for grants to State and local governments. On March 11, 1988, the Common Rule was published in the **Federal Register**. From its inception in January 1989, the Office of National Drug Control Policy (ONDCP) has had

no authority to make grants to State and local entities. Consequently, ONDCP never adopted the Common Rule.

This final rule is identical to the Common Rule, and describes the procedures ONDCP will follow in awarding and administering grants and cooperative agreements pursuant to the Executive Office Appropriations Act of 1993, and any additional grant-making authority ONDCP may have in the future.

EFFECTIVE DATE: This regulation is effective November 24, 1992.

FOR FURTHER INFORMATION CONTACT: Matthew C. Ames, Office of the General Counsel, Office of National Drug Control Policy, Washington, DC 20500, (202) 467–9840.

SUPPLEMENTARY INFORMATION:

Background

The Office of National Drug Control Policy (ONDCP) was created by the Anti-Drug Abuse Act of 1988, Pub. L. 100–690, 21 U.S.C. 1501 *et seq.* ("the Anti-Drug Abuse Act"), and was charged with the development and coordination of national policy toward illegal drugs. The Anti-Drug Abuse Act authorized ONDCP to establish High Intensity Drug Trafficking Areas (HIDTAs) to improve coordination among Federal, State, and local law enforcement agencies and increase Federal resources devoted to combatting drug trafficking in the HIDTAs.

The Executive Office Appropriations Act of 1993, Pub. L. 102–393, 106 Stat. 1729, 1741 (the "Appropriations Act"), requires ONDCP to transfer funds appropriated for the HIDTAs to applicable agencies within 90 days of the enactment of the Appropriations Act. Until the Appropriations Act became law, ONDCP had no authority to make grants to State or local governments, and consequently had never issued grant management regulations. If it is to comply with the 90-day limit imposed by the Act, however, ONDCP must issue such regulations immediately. Consequently, this final rule, which is identical to the common rule published at 53 FR 8087 on March 11, 1988 (the "Common Rule"), and adopted by all other Federal agencies and department's with grant-making authority, is effective November 24, 1992.

Appendix A of the regulations consists of OMB Circular A–128, which was issued by the Office of Management and Budget on April 12, 1985, and published in the **Federal Register** at 50 FR 19114 on May 6, 1985.

Justification For Lack of Notice

The Administrative Procedure Act requires agencies to give the public notice before a rule takes effect, unless the agency shows that it has good cause to do otherwise. ONDCP believes that there is good cause to invoke this exception in this instance, for two reasons. First, the Congress has imposed the time limitation referred to above, which makes it imperative for ONDCP to act quickly. Second, the rule is identical to the Common Rule, which has been adopted by at least 25 other Federal agencies, and has been in effect for over four years. The public has already received ample notice of the rule's terms, and has had the opportunity to comment. Therefore, ONDCP has decided, for good cause under 5 U.S.C. 553(b)(B), not to publish a proposed rulemaking, and to join the governmentwide final common rule.

List of Subjects in 21 CFR Part 1403

Drug traffic control, Grant programs, Grants administration.

For the reasons set out in the preamble, title 21, chapter III, of the Code of Federal Regulations is amended by adding a new part 1403 to read as follows:

PART 1403—UNIFORM ADMINISTRATIVE REQUIREMENTS FOR GRANTS AND COOPERATIVE AGREEMENTS TO STATE AND LOCAL GOVERNMENTS

Subpart A—General

Sec.

Subpart B—Pre-Award Requirements

Subpart C—Post-Award Requirements

FINANCIAL ADMINISTRATION

CHANGES, PROPERTY, AND SUBAWARDS

REPORTS, RECORDS, RETENTION, AND ENFORCEMENT

Subpart D—After-the-Grant Requirements

Subpart E—Entitlement [Reserved]

Authority: 5 U.S.C. 301.

Subpart A—General

§ 1403.1 Purpose and scope of this part.

This part establishes uniform administrative rules for Federal grants and cooperative agreements and subawards to State, local and Indian tribal governments.

§ 1403.2 Scope of subpart.

This subpart contains general rules pertaining to this part and procedures for control of exceptions from this part.

§ 1403.3 Definitions.

As used in this part:

Accrued expenditures mean the charges incurred by the grantee during a given period requiring the provision of funds for:

(1) Goods and other tangible property received;

(2) Services performed by employees, contractors, subgrantees, subcontractors, and other payees; and

(3) Other amounts becoming owed under programs for which no current services or performance is required, such as annuities, insurance claims, and other benefit payments.

Accrued income means the sum of:

(1) Earnings during a given period from services performed by the grantee and goods and other tangible property delivered to purchasers, and

(2) Amounts becoming owed to the grantee for which no current services or performance is required by the grantee.

Acquisition cost of an item of purchased equipment means the net invoice unit price of the property including the cost of modifications, attachments, accessories, or auxiliary apparatus necessary to make the property usable for the purpose for

which it was acquired. Other charges such as the cost of installation, transportation, taxes, duty or protective in-transit insurance, shall be included or excluded from the unit acquisition cost in accordance with the grantee's regular accounting practices.

Administrative requirements mean those matters common to grants in general, such as financial management, kinds and frequency of reports, and retention of records. These are distinguished from "programmatic" requirements, which concern matters that can be treated only on a program-by-program or grant-by-grant basis, such as kinds of activities that can be supported by grants under a particular program.

Awarding agency means:

(1) With respect to a grant, the Federal agency, and

(2) With respect to a subgrant, the party that awarded the subgrant.

Cash contributions means the grantee's cash outlay, including the outlay of money contributed to the grantee or subgrantee by other public agencies and institutions, and private organizations and individuals. When authorized by Federal legislation, Federal funds received from other assistance agreements may be considered as grantee or subgrantee cash contributions.

Contract means (except as used in the definitions for "grant" and "subgrant" in this section and except where qualified by "Federal") a procurement contract under a grant or subgrant, and means a procurement subcontract under a contract.

Cost sharing or matching means the value of the third party in-kind contributions and the portion of the costs of a federally assisted project or program not borne by the Federal Government.

Cost-type contract means a contract or subcontract under a grant in which the contractor or subcontractor is paid on the basis of the costs it incurs, with or without a fee.

Equipment means tangible, nonexpendable, personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. A grantee may use its own definition of equipment provided that such definition would at least include all equipment defined above.

Expenditure report means:

(1) For nonconstruction grants, the SF-269 "Financial Status Report" (or other equivalent report);

(2) For construction grants, the SF-271 "Outlay Report and Request for Reimbursement" (or other equivalent report).

Federally recognized Indian tribal government means the governing body or a governmental agency of any Indian tribe, band, nation, or other organized group or community (including any Native village as defined in section 3 of the Alaska Native Claims Settlement Act, 85 Stat. 688) certified by the Secretary of the Interior as eligible for the special programs and services provided by him through the Bureau of Indian Affairs.

Government means a State or local government or a federally recognized Indian tribal government.

Grant means an award of financial assistance, including cooperative agreements, in the form of money, or property in lieu of money, by the Federal Government to an eligible grantee. The term does not include technical assistance which provides services instead of money, or other assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct appropriations. Also, the term does not include assistance, such as a fellowship or other lump sum award, which the grantee is not required to account for.

Grantee means the government to which a grant is awarded and which is accountable for the use of the funds provided. The grantee is the entire legal entity even if only a particular component of the entity is designated in the grant award document.

Local government means a county, municipality, city, town, township, local public authority (including any public and Indian housing agency under the United States Housing Act of 1937) school district, special district, intrastate district, council of governments (whether or not incorporated as a nonprofit corporation under state law), any other regional or interstate government entity, or any agency or instrumentality of a local government.

Obligations means the amounts of orders placed, contracts and subgrants awarded, goods and services received, and similar transactions during a given period that will require payment by the grantee during the same or a future period.

OMB means the United States Office of Management and Budget.

Outlays (expenditures) means charges made to the project or program. They may be reported on a cash or accrual basis. For reports prepared on a cash basis, outlays are the sum of actual cash disbursement for direct charges for goods and service, the amount of indirect expense incurred, the value of in-kind contributions applied, and the amount of cash advances and payments made to contractors and subgrantees. For reports prepared on an accrued expenditure basis, outlays are the sum of actual cash disbursements, the amount of indirect expense incurred, the value of in-kind contributions applied, and the new increase (or decrease) in the amounts owed by the grantee for goods and other property received, for services performed by employees, contractors, subgrantees, subcontractors, and other payees, and other amounts becoming owed under programs for which no current services or performance are required, such as annuities, insurance claims, and other benefit payments.

Percentage of completion method refers to a system under which payments are made for construction work according to the percentage of completion of the work, rather than to the grantee's cost incurred.

Prior approval means documentation evidencing consent prior to incurring specific cost.

Real property means land, including land improvements, structures and appurtenances thereto, excluding movable machinery and equipment.

Share, when referring to the awarding agency's portion of real property, equipment or supplies, means the same percentage as the awarding agency's portion of the acquiring party's total costs under the grant to which the acquisition costs under the grant to which the acquisition cost of the property was charged. Only costs are to be counted—not the value of third-party in-kind contributions.

State means any of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State exclusive of local governments. The term does not include any public and Indian housing agency under United States Housing Act of 1937.

Subgrant means an award of financial assistance in the form of money, or property in lieu of money, made under a grant by a grantee to an eligible subgrantee. The term includes financial assistance when provided by contractual legal agreement, but does not include procurement purchases, nor does it include any form of assistance which is excluded from the definition of "grant" in this part.

Subgrantee means the government or other legal entity to which a subgrant is awarded and which is accountable to the grantee for the use of the funds provided.

Supplies means all tangible personal property other than "equipment" as defined in this part.

Suspension means depending on the context, either

(1) Temporary withdrawal of the authority to obligate grant funds pending corrective action by the grantee or subgrantee or a decision to terminate the grant, or

(2) In action taken by a suspending official in accordance with agency regulations implementing E.O. 12549 to immediately exclude a person from participating in grant transactions for a period, pending completion of an investigation and such legal or debarment proceedings as may ensue.

Termination means permanent withdrawal of the authority to obligate previously-awarded grant funds before that authority would otherwise expire. It also means the voluntary relinquishment of that authority by the grantee or subgrantee. "Termination" does not include:

(1) Withdrawal of funds awarded on the basis of the grantee's underestimate of the unobligated balance in a prior period;

(2) Withdrawal of the unobligated balance as of the expiration of a grant;

(3) Refusal to extend a grant or award additional funds, to make a competing or noncompeting continuation, renewal, extension, or supplemental award; or

(4) Voiding of a grant upon determination that the award was obtained fraudulently, or was otherwise illegal or invalid from inception.

Terms of a grant or subgrant mean all requirements of the grant or subgrant, whether in statute, regulations, or the award document.

Third party in-kind contributions mean property or services which benefit a federally assisted project or program and which are contributed by non-Federal third parties without charge to the grantee, or a cost-type contractor under the grant agreement.

Unliquidated obligations for reports prepared on a cash basis mean the amount of obligations incurred by the grantee that has not been paid. For reports prepared on an accrued expenditure basis, they represent the amount of obligations incurred by the grantee for which an outlay has not been recorded.

Unobligated balance means the portion of the funds authorized by the Federal agency that has not been obligated by the grantee and is determined by deducting the cumulative obligations from the cumulative funds authorized.

§ 1403.4 Applicability.

(a) *General.* Subparts A–D of this part apply to all grants and subgrants to governments, except where inconsistent with Federal statutes or with regulations authorized in accordance with the exception provision of § 1403.6, or:

(1) Grants and subgrants to State and local institutions of higher education or State and local hospitals;

(2) The block grants authorized by the Omnibus Budget Reconciliation Act of 1981 (Community Services; Preventive Health and Health Services; Alcohol, Drug Abuse, and Mental Health Services; Maternal and Child Health Services; Social Services; Low-Income Home Energy Assistance; States' Program of Community Development Block Grants for Small Cities; and Elementary and Secondary Education other than programs administered by the Secretary of Education under title V, subtitle D, chapter 2, section 583—the Secretary's discretionary grant program) and titles I–III of the Job Training Partnership Act of 1982 and under the Public Health Services Act (Section 1921), Alcohol and Drug Abuse Treatment and Rehabilitation Block Grant and part C of title V, Mental Health Service for the Homeless Block Grant);

(3) Entitlement grants to carry out the following programs of the Social Security Act:

(i) Aid to Needy Families with Dependent Children (title IV–A of the Act, not including the Work Incentive Program (WIN) authorized by section 402(a)19(G); HHS grants for WIN are subject to this part);

(ii) Child Support Enforcement and Establishment of Paternity (title IV–D of the Act);

(iii) Foster Care and Adoption Assistance (title IV–E of the Act);

(iv) Aid to the Aged, Blind, and Disabled (titles I, X, XIV, and XVI–AABD of the Act); and

(v) Medical Assistance (Medicaid) (title XIX of the Act) not including the State Medicaid Fraud Control program authorized by section 1903(a)(6)(B);

(4) Entitlement grants under the following programs of The National School Lunch Act:

(i) School Lunch (section 4 of the Act),

(ii) Commodity Assistance (section 6 of the Act),

(iii) Special Meal Assistance (section 11 of the Act),

(iv) Summer Food Service for Children (section 13 of the Act), and

(v) Child Care Food Program (section 17 of the Act);

(5) Entitlement grants under the following programs of The Child Nutrition Act of 1966:

(i) Special Milk (section 3 of the Act), and

(ii) School Breakfast (section 4 of the Act);

(6) Entitlement grants for State Administrative expenses under The Food Stamp Act of 1977 (section 16 of the Act);

(7) A grant for an experimental, pilot, or demonstration project that is also supported by a grant listed in paragraph (a)(3) of this section;

(8) Grant funds awarded under subsection 412(e) of the Immigration and Nationality Act (8 U.S.C. 1522(e)) and subsection 501(a) of the Refugee Education Assistance Act of 1980 (Pub. L. 96–422, 94 Stat. 1809), for cash assistance, medical assistance, and supplemental security income benefits to refugees and entrants and the administrative costs of providing the assistance and benefits;

(9) Grants to local education agencies under 20 U.S.C. 236 through 241–1(a), and 242 through 244 (portions of the Impact Aid program), except for 20 U.S.C. 238(d)(2)(c) and 240(f) (Entitlement Increase for Handicapped Children); and

(10) Payments under the Veterans Administration's State Home Per Diem Program (38 U.S.C. 641(a)).

(b) *Entitlement programs.* Entitlement programs enumerated above in § 1403.4(a) (3) through (8) are subject to subpart E.

§ 1403.5 Effect on other issuances.

All other grants administration provisions of codified program regulations, program manuals, handbooks and other nonregulatory materials which are inconsistent with this part are superseded, except to the extent they are required by statute, or authorized in accordance with the exception provision in § 1403.6.

§ 1403.6 Additions and exceptions.

(a) For classes of grants and grantees subject to this part, Federal agencies may not impose additional administrative requirements except in codified regulations published in the **Federal Register.**

(b) Exceptions for classes of grants or grantees may be authorized only by OMB.

(c) Exceptions on a case-by-case basis and for subgrantees may be authorized by the affected Federal agencies.

Subpart B—Pre-Award Requirements

§ 1403.10 Forms for applying for grants.

(a) *Scope.* (1) This section prescribes forms and instructions to be used by governmental organizations (except

hospitals and institutions of higher education operated by a government) in applying for grants. This section is not applicable, however, to formula grant programs which do not require applicants to apply for funds on a project basis.

(2) This section applies only to applications to Federal agencies for grants, and is not required to be applied by grantees in dealing with applicants for subgrants. However, grantees are encouraged to avoid more detailed or burdensome application requirements for subgrants.

(b) *Authorized forms and instructions for governmental organizations.* (1) In applying for grants, applicants shall only use standard application forms or those prescribed by the granting agency with the approval of OMB under the Paperwork Reduction Act of 1980.

(2) Applicants are not required to submit more than the original and two copies of preapplications or applications.

(3) Applicants must follow all applicable instructions that bear OMB clearance numbers. Federal agencies may specify and describe the programs, functions, or activities that will be used to plan, budget, and evaluate the work under a grant. Other supplementary instructions may be issued only with the approval of OMB to the extent required under the Paperwork Reduction Act of 1980. For any standard form, except the SF–424 facesheet, Federal agencies may shade out or instruct the applicant to disregard any line item that is not needed.

(4) When a grantee applies for additional funding (such as a continuation or supplemental award) or amends a previously submitted application, only the affected pages need be submitted. Previously submitted pages with information that is still current need not be resubmitted.

§ 1403.11 State plans.

(a) *Scope.* The statutes for some programs require States to submit plans before receiving grants. Under regulations implementing Executive Order 12372, "Intergovernmental Review of Federal Programs," States are allowed to simplify, consolidate and substitute plans. This section contains additional provisions for plans that are subject to regulations implementing the Executive Order.

(b) *Requirements.* A State need meet only Federal administrative or programmatic requirements for a plan that are in statutes or codified regulations.

(c) *Assurances.* In each plan the States will include an assurance that the State shall comply with all applicable Federal statutes and regulations in effect with respect to the periods for which it receives grant funding. For this assurance and other assurances required in the plan, the State may:

(1) Cite by number the statutory or regulatory provisions requiring the assurances and affirm that it gives the assurances required by those provisions,

(2) Repeat the assurance language in the statutes or regulations, or

(3) Develop its own language to the extent permitted by law.

(d) *Amendments.* A State will amend a plan whenever necessary to reflect: (1) New or revised Federal statutes or regulations or (2) a material change in any State law, organization, policy, or State agency operation. The State will obtain approval for the amendment and its effective date but need submit for approval only the amended portions of the plan.

§ 1403.12 Special grant or subgrant conditions for "high-risk" grantees.

(a) A grantee or subgrantee may be considered "high risk" if an awarding agency determines that a grantee or subgrantee:

(1) Has a history of unsatisfactory performance, or

(2) Is not financially stable, or

(3) Has a management system which does not meet the management standards set forth in this part, or

(4) Has not conformed to terms and conditions of previous awards, or

(5) Is otherwise not responsible; and if the awarding agency determines that an award will be made, special conditions and/or restrictions shall correspond to the high risk condition and shall be included in the award.

(b) Special conditions or restrictions may include:

(1) Payment on a reimbursement basis;

(2) Withholding authority to proceed to the next phase until receipt of evidence of acceptable performance within a given funding period;

(3) Requiring additional, more detailed financial reports;

(4) Additional project monitoring;

(5) Requiring the grantee or subgrantee to obtain technical or management assistance; or

(6) Establishing additional prior approvals;

(c) If an awarding agency decides to impose such conditions, the awarding official will notify the grantee or subgrantee as early as possible, in writing, of:

(1) The nature of the special conditions/restrictions;

(2) The reason(s) for imposing them;

(3) The corrective actions which must be taken before they will be removed and the time allowed for completing the corrective actions; and

(4) The method of requesting reconsideration of the conditions/restrictions imposed.

Subpart C—Post-Award Requirements

Financial Administration

§ 1403.20 Standards for financial management systems.

(a) A State must expend and account for grant funds in accordance with State laws and procedures for expending and accounting for its own funds. Fiscal control and accounting procedures of the State, as well as its subgrantees and cost-type contractors, must be sufficient to—

(1) Permit preparation of reports required by this part and the statutes authorizing the grant, and

(2) Permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of applicable statutes.

(b) The financial management systems of other grantees and subgrantees must meet the following standards:

(1) *Financial reporting.* Accurate, current, and complete disclosure of the financial results of financially assisted activities must be made in accordance with the financial reporting requirements of the grant or subgrant.

(2) *Accounting records.* Grantees and subgrantees must maintain records which adequately identify the source and application of funds provided for financially-assisted activities. These records must contain information pertaining to grant or subgrant awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income.

(3) *Internal control.* Effective control and accountability must be maintained for all grant and subgrant cash, real and personal property, and other assets. Grantees and subgrantees must adequately safeguard all such property and must assure that it is used solely for authorized purposes.

(4) *Budget control.* Actual expenditures or outlays must be compared with budgeted amounts for each grant or subgrant. Financial information must be related to performance or productivity data, including the development of unit cost information whenever appropriate or specifically required in the grant or subgrant agreement. If unit cost data are required, estimates based on available

documentation will be accepted whenever possible.

(5) *Allowable cost.* Applicable OMB cost principles, agency program regulations, and the terms of grant and subgrant agreements will be followed in determining the reasonableness, allowability, and allocability of costs.

(6) *Source documentation.* Accounting records must be supported by such source documentation as canceled checks, paid bills, payrolls, time and attendance records, contract and subgrant award documents, etc.

(7) *Cash management.* Procedures for minimizing the time elapsing between the transfer of funds from the U.S. Treasury and disbursement by grantees and subgrantees must be followed whenever advance payment procedures are used. Grantees must establish reasonable procedures to ensure the receipt of reports on subgrantees' cash balances and cash disbursements in sufficient time to enable them to prepare complete and accurate cash transactions reports to the awarding agency. When advances are made by letter-of-credit or electronic transfer of funds methods, the grantee must make drawdowns as close as possible to the time of making disbursements. Grantees must monitor cash drawdowns by their subgrantees to assure that they conform substantially to the same standards of timing and amount as apply to advances to the grantees.

(c) An awarding agency may review the adequacy of the financial management system of any applicant for financial assistance as part of a preaward review or at any time subsequent to award.

§ 1403.21 Payment.

(a) *Scope.* This section prescribes the basic standard and the methods under which a Federal agency will make payments to grantees, and grantees will make payments to subgrantees and contractors.

(b) *Basic standard.* Methods and procedures for payment shall minimize the time elapsing between the transfer of funds and disbursement by the grantee or subgrantee, in accordance with Treasury regulations at 31 CFR part 205.

(c) *Advances.* Grantees and subgrantees shall be paid in advance, provided they maintain or demonstrate the willingness and ability to maintain procedures to minimize the time elapsing between the transfer of the funds and their disbursement by the grantee or subgrantee.

(d) *Reimbursement.* Reimbursement shall be the preferred method when the requirements in paragraph (c) of this section are not met. Grantees and subgrantees may also be paid by reimbursement for any construction grant. Except as otherwise specified in regulation, Federal agencies shall not use the percentage of completion method to pay construction grants. The grantee or subgrantee may use that method to pay its construction contractor, and if it does, the awarding agency's payments to the grantee or subgrantee will be based on the grantee's or subgrantee's actual rate of disbursement.

(e) *Working capital advances.* If a grantee cannot meet the criteria for advance payments described in paragraph (c) of this section, and the Federal agency has determined that reimbursement is not feasible the grantee lacks sufficient working capital, the awarding agency may provide cash or a working capital advance basis. Under this procedure the awarding agency shall advance cash to the grantee to cover its estimated disbursement needs for an initial period generally geared to the grantee's disbursing cycle. Thereafter, the awarding agency shall reimburse the grantee for its actual cash disbursements. The working capital advance method of payment shall not be used by grantees or subgrantees if the reason for using such method is the unwillingness or inability of the grantee to provide timely advances to the subgrantee to meet the subgrantee's actual cash disbursements.

(f) *Effect of program income, refunds, and audit recoveries on payment.* (1) Grantees and subgrantees shall disburse repayments to and interest earned on a revolving fund before requesting additional cash payments for the same activity.

(2) Except as provided in paragraph (f)(1) of this section, grantees and subgrantees shall disburse program income, rebates, refunds, contract settlements, audit recoveries and interest earned on such funds before requesting additional cash payments.

(g) *Withholding payments.* (1) Unless otherwise required by Federal statute, awarding agencies shall not withhold payments for proper charges incurred by grantees or subgrantees unless——

(i) The grantee or subgrantee has failed to comply with grant award conditions or

(ii) The grantee or subgrantee is indebted to the United States.

(2) Cash withheld for failure to comply with grant award condition, but without suspension of the grant, shall be released to the grantee upon subsequent compliance. When a grant is suspended, payment adjustments will be made in accordance with § 1403.43(c).

(3) A Federal agency shall not make payment to grantees for amounts that are withheld by grantees or subgrantees from payment to contractors to assure satisfactory completion of work. Payments shall be made by the Federal agency when the grantees or subgrantees actually disburse the withheld funds to the contractors or to escrow accounts established to assure satisfactory completion of work.

(h) *Cash depositories.* (1) Consistent with the national goal of expanding the opportunities for minority business enterprises, grantees and subgrantees are encouraged to use minority banks (a bank which is owned at least 50 percent by minority group members). A list of minority owned banks can be obtained from the Minority Business Development Agency, Department of Commerce, Washington, DC 20230.

(2) A grantee or subgrantee shall maintain a separate bank account only when required by Federal-State agreement.

(i) *Interest earned on advances.* Except for interest earned on advances of funds exempt under the Intergovernmental Cooperation Act (31 U.S.C. 6501 et seq.) and the Indian Self-Determination Act (23 U.S.C. 450), grantees and subgrantees shall promptly, but at least quarterly, remit interest earned on advances to the Federal agency. The grantee or subgrantee may keep interest amounts up to $100 per year for administrative expenses.

§ 1403.22 Allowable costs.

(a) *Limitation on use of funds.* Grant funds may be used only for:

(1) The allowable costs of the grantees, subgrantees and cost-type contractors, including allowable costs in the form of payments to fixed-price contractors; and

(2) Reasonable fees or profit to cost-type contractors but not any fee or profit (or other increment above allowable costs) to the grantee or subgrantee.

(b) *Applicable cost principles.* For each kind of organization, there is a set of Federal principles for determining allowable costs. Allowable costs will be determined in accordance with the cost principles applicable to the organization incurring the costs. The following chart lists the kinds of organizations and the applicable cost principles.

For the costs of a—	Use the principles in—
State, local or Indian tribal government.	OMB Circular A-87

For the costs of a—	Use the principles in—
Private nonprofit organization other than (1) institution of higher education, (2) hospital, or (3) organization named in OMB Circular A-122 as not subject to that circular.	OMB Circular A-122.
Educational institutions	OMB Circular A-21.
For-profit organizations other than a hospital and an organization named in OMB Circular A-122 as not subject to that circular.	48 CFR part 31. Contract Cost Principles and Procedures, or uniform cost accounting standards that comply with cost principles acceptable to the Federal agency.

§ 1403.23 Period of availability of funds.

(a) *General.* Where a funding period is specified, a grantee may charge to the award only costs resulting from obligations of the funding period unless carryover of unobligated balances is permitted, in which case the carryover balances may be charged for costs resulting from obligations of the subsequent funding period.

(b) *Liquidation of obligations.* A grantee must liquidate all obligations incurred under the award not later than 90 days after the end of the funding period (or as specified in a program regulation) to coincide with the submission of the annual Financial Status Report (SF-269). The Federal agency may extend this deadline at the request of the grantee.

§ 1403.24 Matching or cost sharing.

(a) *Basic rule: Costs and contributions acceptable.* With the qualifications and exceptions listed in paragraph (b) of this section, a matching or cost sharing requirement may be satisfied by either or both of the following:

(1) Allowable costs incurred by the grantee, subgrantee or a cost-type contractor under the assistance agreement. This includes allowable costs borne by non-Federal grants or by others cash donations from non-Federal third parties.

(2) The value of third party in-kind contributions applicable to the period to which the cost sharing or matching requirements applies.

(b) *Qualifications and exceptions*—(1) *Costs borne by other Federal grant agreements.* Except as provided by Federal statute, a cost sharing or matching requirement may not be met by costs borne by another Federal grant. This prohibition does not apply to income earned by a grantee or subgrantee from a contract awarded under another Federal grant.

(2) *General revenue sharing.* For the purpose of this section, general revenue sharing funds distributed under 31 U.S.C. 6702 are not considered Federal grant funds.

(3) *Cost or contributions counted towards other Federal cost-sharing requirements.* Neither costs nor the values of third party in-kind contributions may count towards satisfying a cost sharing or matching requirement of a grant agreement if they have been or will be counted towards satisfying a cost sharing or matching requirement of another Federal grant agreement, a Federal procurement contract, or any other award of Federal funds.

(4) *Costs financed by program income.* Costs financed by program income, as defined in § 1403.25, shall not count towards satisfying a cost sharing or matching requirement unless they are expressly permitted in the terms of the assistant agreement. (This use of general program income is described in § 1403.25(g).)

(5) *Services or property financed by income earned by contractors.* Contractors under a grant may earn income from the activities carried out under the contract in addition to the amounts earned from the party awarding the contract. No costs of services or property supported by this income may count toward satisfying cost sharing or matching requirement unless other provisions of the grant agreement expressly permit this kind of income to be used to meet the requirement.

(6) *Records.* Costs and third party in-kind contributions counting towards satisfying a cost sharing or matching requirement must be verifiable from the records of grantees and subgrantee or cost-type contractors. These records must show how the value placed on third party in-kind contributions was derived. To the extent feasible, volunteer services will be supported by the same methods that the organization uses to support the allocability of regular personnel costs.

(7) *Special standards for third party in-kind contributions.* (i) Third party in-kind contributions count towards satisfying a cost sharing or matching requirement only where, if the party receiving the contributions were to pay for them, the payments would be allowable costs.

(ii) Some third party in-kind contributions are goods and services that, if the grantee, subgrantee, or contractor receiving the contribution had to pay for them, the payments would have been an indirect costs. Costs sharing or matching credit for such contributions shall be given only if the grantee, subgrantee, or contractor has established, along with its regular indirect cost rate, a special rate for allocating to individual projects or programs the value of the contributions.

(iii) A third party in-kind contribution to a fixed-price contract may count towards satisfying a cost sharing or matching requirement only if it results in:

(A) An increase in the services or property provided under the contract (without additional cost to the grantee or subgrantee) or

(B) A cost savings to the grantee or subgrantee.

(iv) The values placed on third party in-kind contributions for cost sharing or matching purposes will conform to the rules in the succeeding sections of this part. If a third party in-kind contribution is a type not treated in those sections, the value placed upon it shall be fair and reasonable.

(c) *Valuation of donated services*—(1) *Volunteer services.* Unpaid services provided to a grantee or subgrantee by individuals will be valued at rates consistent with those ordinarily paid for similar work in the grantee's or subgrantee's organization. If the grantee or subgrantee does not have employees performing similar work, the rates will be consistent with those ordinarily paid by other employers for similar work in the same labor market. In either case, a reasonable amount for fringe benefits may be included in the valuation.

(2) *Employees of other organizations.* When an employer other than a grantee, subgrantee, or cost-type contractor furnishes free of charge the services of an employee in the employee's normal line of work, the services will be valued at the employee's regular rate of pay exclusive of the employee's fringe benefits and overhead costs. If the services are in a different line of work, paragraph (c)(1) of this section applies.

(d) *Valuation of third party donated supplies and loaned equipment or space* (1) If a third party donates supplies, the contribution will be valued at the market value of the supplies at the time of donation.

(2) If a third party donates the use of equipment or space in a building but retains title, the contribution will be valued at the fair rental rate of the equipment or space.

(e) *Valuation of third party donated equipment, buildings, and land.* If a third party donates equipment, buildings, or land, and title passes to a grantee or subgrantee, the treatment of the donated

property will depend upon the purpose of the grant or subgrant, as follows:

(1) *Awards for capital expenditures.* If the purpose of the grant or subgrant is to assist the grantee or subgrantee in the acquisition of property, the market value of that property at the time of donation may be counted as cost sharing or matching.

(2) *Other awards.* If assisting in the acquisition of property is not the purpose of the grant or subgrant, paragraphs (e)(2) (i) and (ii) of this section apply:

(i) If approval is obtained from the awarding agency, the market value at the time of donation of the donated equipment or buildings and the fair rental rate of the donated land may be counted as cost sharing or matching. In the case of a subgrant, the terms of the grant agreement may require that the approval be obtained from the Federal agency as well as the grantee. In all cases, the approval may be given only if a purchase of the equipment or rental of the land would be approved as an allowable direct cost. If any part of the donated property was acquired with Federal funds, only the non-federal share of the property may be counted as cost-sharing or matching.

(ii) If approval is not obtained under paragraph (e)(2)(i) of this section, no amount may be counted for donated land, and only depreciation or use allowances may be counted for donated equipment and buildings. The depreciation or use allowances for this property are not treated as third party in-kind contributions. Instead, they are treated as costs incurred by the grantee or subgrantee. They are computed and allocated (usually as indirect costs) in accordance with the cost principles specified in § 1403.22, in the same way as depreciation or use allowances for purchased equipment and buildings. The amount of depreciation or use allowances for donated equipment and buildings is based on the property's market value at the time it was donated.

(f) *Valuation of grantee or subgrantee donates real property for construction/acquisition.* If a grantee or subgrantee donates real property for a construction or facilities acquisition project, the current market value of that property may be counted as cost sharing or matching. If any part of the donated property was acquired with Federal funds, only the non-federal share of the property may be counted as cost sharing or matching.

(g) *Appraisal of real property.* In some cases under paragraphs (d), (e) and (f) of this section, it will be necessary to establish the market value of land or a building or the fair rental rate of land or of space in a building. In these cases, the Federal agency may require the market value or fair rental value be set by an independent appraiser, and that the value or rate be certified by the grantee. This requirement will also be imposed by the grantee on subgrantees.

§ 1403.25 Program income.

(a) *General.* Grantees are encouraged to earn income to defray program costs. Program income includes income from fees for services performed, from the use of rental of real or personal property acquired with grant funds, from the sale of commodities or items fabricated under a grant agreement, and from payments of principal and interest on loans made with grant funds. Except as otherwise provided in regulations of the Federal agency, program income does not include interest on grant funds, rebates, credits, discounts, refunds, etc., and interest earned on any of them.

(b) *Definition of program income.* Program income means gross income received by the grantee or subgrantee directly generated by a grant supported activity, or earned only as a result of the grant agreement during the grant period. "During the grant period" is the time between the effective date of the award and the ending date of the award reflected in the final financial report.

(c) *Cost of generating program income.* If authorized by Federal regulations or the grant agreement, costs incident to the generation of program income may be deducted from gross income to determine program income.

(d) *Governmental revenues.* Taxes, special assessments levies, fines, and other such revenues raised by a grantee or subgrantee are not program income unless the revenues are specifically identified in the grant agreement or Federal agency regulations as program income.

(e) *Royalties.* Income from royalties and license fees for copyrighted material, patents, and inventions developed by a grantee or subgrantee is program income only if the revenues are specifically identified in the grant agreement or Federal agency regulations as program income. (See § 1403.34.)

(f) *Property.* Proceeds from the sale of real property or equipment will be handled in accordance with the requirements of § 1403.31 and § 1403.32.

(g) *Use of program income.* Program income shall be deducted from outlays which may be both Federal and non-Federal as described below, unless the Federal agency regulations or the grant agreement specify another alternative (or a combination of the alternatives). In specifying alternatives, the Federal agency may distinguish between income earned by the grantee and income earned by subgrantees and between the sources, kinds, or amounts of income. When Federal agencies authorize the alternatives in paragraphs (g) (2) and (3) of this section, program income in excess of any limits stipulated shall also be deducted from outlays.

(1) *Deduction.* Ordinarily program income shall be deducted from total allowable costs to determine the net allowable costs. Program income shall be used for current costs unless the Federal agency authorizes otherwise. Program income which the grantee did not anticipate at the time of the award shall be used to reduce the Federal agency and grantee contributions rather than to increase the funds committed to the project.

(2) *Addition.* When authorized, program income may be added to the funds committed to the grant agreement by the Federal agency and the grantee. The program income shall be used for the purposes and under the conditions of the grant agreement.

(3) *Cost sharing or matching.* When authorized, program income may be used to meet the cost sharing or matching requirement of the grant agreement. The amount of the Federal grant award remains the same.

(h) *Income after the award period.* There are no Federal requirements governing the disposition of program income earned after the end of the award period (i.e., until the ending date of the final financial report, see paragraph (a) of this section), unless the terms of the agreement or the Federal agency regulations provide otherwise.

§ 1403.26 Non-Federal audit.

(a) *Basic rule.* Grantees and subgrantees are responsible for obtaining audits in accordance with the Single Audit Act of 1984 (31 U.S.C. 7501–7) and Federal agency implementing regulations. The audits shall be made by an independent auditor in accordance with generally accepted government auditing standards covering financial and compliance audits.

(b) *Subgrantees.* State or local governments, as those terms are defined for purposes of the Single Audit Act, that receive Federal financial assistance and provide $25,000 or more of it in a fiscal year to a subgrantee shall:

(1) Determine whether State or local subgrantees have met the audit requirements of the Act and whether subgrantees covered by OMB Circular A–110, "Uniform Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals and Other Nonprofit

Organizations" have met the audit requirement. Commercial contractors (private for profit and private and governmental organizations) providing goods and services to State and local governments are not required to have a single audit performed. State and local governments should use their own procedures to ensure that the contractor has complied with laws and regulations affecting the expenditure of Federal funds;

(2) Determine whether the subgrantee spent Federal assistance funds provided in accordance with applicable laws and regulations. This may be accomplished by reviewing an audit of the subgrantee made in accordance with the Act, Circular A-110, or through other means (e.g., program reviews) if the subgrantee has not had such an audit;

(3) Ensure that appropriate corrective action is taken within six months after receipt of the audit report in instance of noncompliance with Federal laws and regulations;

(4) Consider whether subgrantee audits necessitate adjustment of the grantee's own records; and

(5) Require each subgrantee to permit independent auditors to have access to the records and financial statements.

(c) *Auditor selection.* In arranging for audit services, § 1403.36 shall be followed.

Changes, Property, and Subawards

§ 1403.30 Changes.

(a) *General.* Grantees and subgrantees are permitted to rebudget within the approved direct cost budget to meet unanticipated requirements and may make limited program changes to the approved project. However, unless waived by the awarding agency, certain types of post-award changes in budgets and projects shall require the prior written approval of the awarding agency.

(b) *Relation to cost principles.* The applicable cost principles (see § 1403.22) contain requirements for prior approval of certain types of costs. Except where waived, those requirements apply to all grants and subgrants even if paragraphs (c) through (f) of this section do not.

(c) *Budget changes*—(1) *Nonconstruction projects.* Except as stated in other regulations or an award document, grantees or subgrantees shall obtain the prior approval of the awarding agency whenever any of the following changes is anticipated under a nonconstruction award:

(i) Any revision which would result in the need for additional funding.

(ii) Unless waived by the awarding agency, cumulative transfers among direct cost categories, or, if applicable, among separately budgeted programs, projects, functions, or activities which exceed or are expected to exceed ten percent of the current total approved budget, whenever the awarding agency's share exceeds $100,000.

(iii) Transfer of funds allotted for training allowances (i.e., from direct payments to trainees to other expense categories).

(2) *Construction projects.* Grantees and subgrantees shall obtain prior written approval for any budget revision which would result in the need for additional funds.

(3) *Combined construction and nonconstruction projects.* When a grant or subgrant provides funding for both construction and nonconstruction activities, the grantee or subgrantee must obtain prior written approval from the awarding agency before making any fund or budget transfer from nonconstruction to construction or vice versa.

(d) *Programmatic changes.* Grantees or subgrantees must obtain the prior approval of the awarding agency whenever any of the following actions is anticipated:

(1) Any revision of the scope or objectives of the project (regardless of whether there is an associated budget revision requiring prior approval).

(2) Need to extend the period of availability of funds.

(3) Changes in key persons in cases where specified in an application or a grant award. In research projects, a change in the project director or principal investigator shall always require approval unless waived by the awarding agency.

(4) Under nonconstruction projects, contracting out, subgranting (if authorized by law) or otherwise obtaining the services of a third party to perform activities which are central to the purposes of the award. This approval requirement is in addition to the approval requirements of § 1403.36 but does not apply to the procurement of equipment, supplies, and general support services.

(e) *Additional prior approval requirements.* The awarding agency may not require prior approval for any budget revision which is not described in paragraph (c) of this section.

(f) *Requesting prior approval.* (1) A request for prior approval of any budget revision will be in the same budget format the grantee used in its application and shall be accompanied by a narrative justification for the proposed revision.

(2) A request for a prior approval under the applicable Federal cost principles (see § 1403.22) may be made by letter.

(3) A request by a subgrantee for prior approval will be addressed in writing to the grantee. The grantee will promptly review such request and shall approve or disapprove the request in writing. A grantee will not approve any budget or project revision which is inconsistent with the purpose or terms and conditions of the Federal grant to the grantee. If the revision requested by the subgrantee would result in a change to the grantee's approved project which requires Federal prior approval, the grantee will obtain the Federal agency's approval before approving the subgrantee's request.

§ 1403.31 Real property.

(a) *Title.* Subject to the obligations and conditions set forth in this section, title to real property acquired under a grant or subgrant will vest upon acquisition in the grantee or subgrantee respectively.

(b) *Use.* Except as otherwise provided by Federal statutes, real property will be used for the originally authorized purposes as long as needed for those purposes, and the grantee or subgrantee shall not dispose of or encumber its title or other interests.

(c) *Disposition.* When real property is no longer needed for the originally authorized purpose, the grantee or subgrantee will request disposition instructions from the awarding agency. The instructions will provide for one of the following alternatives:

(1) *Retention of title.* Retain title after compensating the awarding agency. The amount paid to the awarding agency will be computed by applying the awarding agency's percentage of participation in the cost of the original purchase to the fair market value of the property. However, in those situations were a grantee or subgrantee is disposing of real property acquired with grant funds and acquiring replacement real property under the same program, the net proceeds from the disposition may be used as an offset to the cost of the replacement property.

(2) *Sale of property.* Sell the property and compensate the awarding agency. The amount due to the awarding agency will be calculated by applying the awarding agency's percentage of participation in the cost of the original purchase to the proceeds of the sale after deduction of any actual and reasonable selling and fixing-up expenses. If the grant is still active, the net proceeds from sale may be offset against the original cost of the property. When a grantee or subgrantee is

directed to sell property, sales procedures shall be followed that provide for competition to the extent practicable and result in the highest possible return.

(3) *Transfer of title.* Transfer title to the awarding agency or to a third-party designated/approved by the awarding agency. The grantee or subgrantee shall be paid an amount calculated by applying the grantee or subgrantee's percentage of participation in the purchase of the real property to the current fair market value of the property.

§ 1403.32 Equipment.

(a) *Title.* Subject to the obligations and conditions set forth in this section, title to equipment acquired under a grant or subgrant will vest upon acquisition in the grantee or subgrantee respectively.

(b) *States.* A State will use, manage, and dispose of equipment acquired under a grant by the State in accordance with State laws and procedures. Other grantees and subgrantees will follow paragraphs (c) through (e) of this section.

(c) *Use.* (1) Equipment shall be used by the grantee or subgrantee in the program or project for which it was acquired as long as needed, whether or not the project or program continues to be supported by Federal funds. When no longer needed for the original program or project, the equipment may be used in other activities currently or previously supported by a Federal agency.

(2) The grantee or subgrantee shall also make equipment available for use on other projects or programs currently or previously supported by the Federal Government, providing such use will not interfere with the work on the projects or program for which it was originally acquired. First preference for other use shall be given to other programs or projects supported by the awarding agency. User fees should be considered if appropriate.

(3) Notwithstanding the encouragement in § 1403.25(a) to earn program income, the grantee or subgrantee must not use equipment acquired with grant funds to provide services for a fee to compete unfairly with private companies that provide equivalent services, unless specifically permitted or contemplated by Federal statute.

(4) When acquiring replacement equipment, the grantee or subgrantee may use the equipment to be replaced as a trade-in or sell the property and use the proceeds to offset the cost of the replacement property, subject to the approval of the awarding agency.

(d) *Management requirements.* Procedures for managing equipment (including replacement equipment), whether acquired in whole or in part with grant funds, until disposition takes place will, as a minimum, meet the following requirements:

(1) Property records must be maintained that include a description of the property, a serial number or other identification number, the source of property, who holds title, the acquisition date, and cost of the property, percentage of Federal participation in the cost of the property, the location, use and condition of the property, and any ultimate disposition data including the date of disposal and sale price of the property.

(2) A physical inventory of the property must be taken and the results reconciled with the property records at least once every two years.

(3) A control system must be developed to ensure adequate safeguards to prevent loss, damage, or theft of the property. Any loss, damage, or theft shall be investigated.

(4) Adequate maintenance procedures must be developed to keep the property in good condition.

(5) If the grantee or subgrantee is authorized or required to sell the property, proper sales procedures must be established to ensure the highest possible return.

(e) *Disposition.* When original or replacement equipment acquired under a grant or subgrant is no longer needed for the original project or program or for other activities currently or previously supported by a Federal agency, disposition of the equipment will be made as follows:

(1) Items of equipment with a current per-unit fair market value of less than $5,000 may be retained, sold or otherwise disposed of with no further obligation to the awarding agency.

(2) Items of equipment with a current per unit fair market value in excess of $5,000 may be retained or sold and the awarding agency shall have a right to an amount calculated by multiplying the current market value or proceeds from sale by the awarding agency's share of the equipment.

(3) In cases where a grantee or subgrantee fails to take appropriate disposition actions, the awarding agency may direct the grantee or subgrantee to take excess and disposition actions.

(f) *Federal equipment.* In the event a grantee or subgrantee is provided federally-owned equipment:

(1) Title will remain vested in the Federal Government.

(2) Grantees or subgrantees will manage the equipment in accordance with Federal agency rules and procedures, and submit an annual inventory listing.

(3) When the equipment is no longer needed, the grantee or subgrantee will request disposition instructions from the Federal agency.

(g) *Right to transfer title.* The Federal awarding agency may reserve the right to transfer title to the Federal Government or a third party named by the awarding agency when such a third party is otherwise eligible under existing statutes. Such transfers shall be subject to the following standards:

(1) The property shall be identified in the grant or otherwise made known to the grantee in writing.

(2) The Federal awarding agency shall issue disposition instruction within 120 calendar days after the end of the Federal support of the project for which it was acquired. If the federal awarding agency fails to issue disposition instructions within the 120 calendar-day period the grantee shall follow § 1403.32(e).

(3) When title to equipment is transferred, the grantee shall be paid an amount calculated by applying the percentage of participation in the purchase to the current fair market value of the property.

§ 1403.33 Supplies.

(a) *Title.* Title to supplies acquired under a grant or subgrant will vest, upon acquisition, in the grantee or subgrantee respectively.

(b) *Disposition.* If there is a residual inventory of unused supplies exceeding $5,000 in total aggregate fair market value upon termination or completion of the award, and if the supplies are not needed for any other federally sponsored programs or projects, the grantee or subgrantee shall compensate the awarding agency for its share.

§ 1403.34 Copyrights.

The Federal awarding agency reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for Federal Government purposes:

(a) The copyright in any work developed under a grant, subgrant, or contract under a grant or subgrant; and

(b) Any rights of copyright to which a grantee, subgrantee or a contractor purchases ownership with grant support.

§ 1403.35 Subawards to debarred and suspended parties.

Grantees and subgrantees must not make any award or permit any award (subgrant or contract) at any tier to any

party which is debarred or suspended or is otherwise excluded from or ineligible for participation in Federal assistance programs under Executive Order 12549, "Debarment and Suspension."

§ 1403.36 Procurement.

(a) *States.* When procuring property and services under a grant, a State will follow the same policies and procedures it uses for procurements from its non-Federal funds. The State will ensure that every purchase order or other contract includes any clauses required by Federal statutes and executive orders and their implementing regulations. Other grantees and subgrantees will follow paragraphs (b) through (i) of this section.

(b) *Procurement standards.* (1) Grantees and subgrantees will use their own procurement procedures which reflect applicable State and local laws and regulations, provided that the procurements conform to applicable Federal law and the standards identified in this section.

(2) Grantees and subgrantees will maintain a contract administration system which ensures that contractors perform in accordance with the terms, conditions, and specifications of their contracts or purchase orders.

(3) Grantees and subgrantees will maintain a written code of standards of conduct governing the performance of their employees engaged in the award and administration of contracts. No employee, officer or agent of the grantee or subgrantee shall participate in selection, or in the award or administration of a contract supported by Federal funds if a conflict of interest, real or apparent, would be involved. Such a conflict would arise when:

(i) The employee, officer or agent,

(ii) Any member of his immediate family,

(iii) His or her partner, or

(iv) An organization which employs, or is about to employ, any of the above, has a financial or other interest in the firm selected for award. The grantee's or subgrantee's officers, employees or agents will neither solicit nor accept gratuities, favors or anything of monetary value from contractors, potential contractors, or parties to subagreements. Grantee and subgrantees may set minimum rules where the financial interest is not substantial or the gift is an unsolicited item of nominal intrinsic value. To the extent permitted by State or local law or regulations, such standards or conduct will provide for penalties, sanctions, or other disciplinary actions for violations of such standards by the grantee's and subgrantee's officers, employees, or agents, or by contractors or their agents. The awarding agency may in regulation provide additional prohibitions relative to real, apparent, or potential conflicts of interest.

(4) Grantee and subgrantee procedures will provide for a review of proposed procurements to avoid purchase of unnecessary or duplicative items. Consideration should be given to consolidating or breaking out procurements to obtain a more economical purchase. Where appropriate, an analysis will be made of lease versus purchase alternatives, and any other appropriate analysis to determine the most economical approach.

(5) To foster greater economy and efficiency, grantees and subgrantees are encouraged to enter into State and local intergovernmental agreements for procurement or use of common goods and services.

(6) Grantees and subgrantees are encouraged to use Federal excess and surplus property in lieu of purchasing new equipment and property whenever such use is feasible and reduces project costs.

(7) Grantees and subgrantees are encouraged to use value engineering clauses in contracts for construction projects of sufficient size to offer reasonable opportunities for cost reductions. Value engineering is a systematic and creative analysis of each contract item or task to ensure that its essential function is provided at the overall lower cost.

(8) Grantees and subgrantees will make awards only to responsible contractors possessing the ability to perform successfully under the terms and conditions of a proposed procurement. Consideration will be given to such matters as contractor integrity, compliance with public policy, record of past performance, and financial and technical resources.

(9) Grantees and subgrantees will maintain records sufficient to detail the significant history of a procurement. These records will include, but are not necessarily limited to the following: rationale for the method of procurement, selection of contract type, contractor selection or rejection, and the basis for the contract price.

(10) Grantees and subgrantees will use time and material type contracts only—

(i) After a determination that no other contract is suitable, and

(ii) If the contract includes a ceiling price that the contractor exceeds at its own risk.

(11) Grantees and subgrantees alone will be responsible, in accordance with good administrative practice and sound business judgment, for the settlement of all contractual and administrative issues arising out of procurements. These issues include, but are not limited to source evaluation, protests, disputes, and claims. These standards do not relieve the grantee or subgrantee of any contractual responsibilities under its contracts. Federal agencies will not substitute their judgment for that of the grantee or subgrantee unless the matter is primarily a Federal concern. Violations of law will be referred to the local, State, or Federal authority having proper jurisdiction.

(12) Grantees and subgrantees will have protest procedures to handle and resolve disputes relating to their procurements and shall in all instances disclose information regarding the protest to the awarding agency. A protestor must exhaust all administrative remedies with the grantee and subgrantee before pursuing a protest with the Federal agency. Reviews of protests by the Federal agency will be limited to:

(i) Violations of Federal law or regulations and the standards of this section (violations of State or local law will be under the jurisdiction of State or local authorities) and

(ii) Violations of the grantee's or subgrantee's protest procedures for failure to review a complaint or protest. Protests received by the Federal agency other than those specified above will be referred to the grantee or subgrantee.

(c) *Competition.* (1) All procurement transactions will be conducted in a manner providing full and open competition consistent with the standards of § 1403.36. Some of the situations considered to be restrictive of competition include but are not limited to:

(i) Placing unreasonable requirements on firms in order for them to qualify to do business,

(ii) Requiring unnecessary experience and excessive bonding,

(iii) Noncompetitive pricing practices between firms or between affiliated companies,

(iv) Noncompetitive awards to consultants that are on retainer contracts,

(v) Organizational conflicts of interest,

(vi) Specifying only a "brand name" product instead of allowing "an equal" product to be offered and describing the performance of other relevant requirements of the procurement, and

(vii) Any arbitrary action in the procurement process.

(2) Grantees and subgrantees will conduct procurements in a manner that prohibits the use of statutorily or administratively imposed in-State or local geographical preferences in the evaluation of bids or proposals, except in those cases where applicable Federal statutes expressly mandate or encourage geographic preference. Nothing in this section preempts State licensing laws. When contracting for architectural and engineering (A/E) services, geographic location may be a selection criteria provided its application leaves an appropriate number of qualified firms, given the nature and size of the project, to compete for the contract.

(3) Grantees will have written selection procedures for procurement transactions. These procedures will ensure that all solicitations:

(i) Incorporate a clear and accurate description of the technical requirements for the material, product, or service to be procured. Such description shall not, in competitive procurements, contain features which unduly restrict competition. The description may include a statement of the qualitative nature of the material, product or service to be procured, and when necessary, shall set forth those minimum essential characteristics and standards to which it must conform if it is to satisfy its intended use. Detailed product specifications should be avoided if at all possible. When it is impractical or uneconomical to make a clear and accurate description of the technical requirements, a "brand name or equal" description may be used as a means to define the performance or other salient requirements of a procurement. The specific features of the named brand which must be met by offerors shall be clearly stated; and

(ii) Identify all requirements which the offerors must fulfill and all other factors to be used in evaluating bids or proposals.

(4) Grantees and subgrantees will ensure that all prequalified lists of persons, firms, or products which are used in acquiring goods and services are current and include enough qualified sources to ensure maximum open and free competition. Also, grantees and subgrantees will not preclude potential bidders from qualifying during the solicitation period.

(d) *Methods of procurement to be followed—.* (1) *Procurement by small purchase procedures.* Small purchase procedures are those relatively simple and informal procurement methods for securing services, supplies, or other property that do not cost more than $25,000 in the aggregate. If small purchase procurements are used, price or rate quotations will be obtained from an adequate number of qualified sources.

(2) *Procurement by sealed bids (formal advertising).* Bids are publicly solicited and a firm-fixed-price contract (lump sum or unit price) is awarded to the responsible bidder whose bid, conforming with all the material terms and conditions of the invitation for bids, is the lowest in price. The sealed bid method is the preferred method for procuring construction, if the conditions in § 1403.36(d)(2)(i) apply.

(i) In order for sealed bidding to be feasible, the following conditions should be present:

(A) A complete, adequate, and realistic specification or purchase description is available;

(B) Two or more responsible bidders are willing and able to complete effectively for the business; and

(C) The procurement lends itself to a firm fixed price contract and the selection of the successful bidder can be made principally on the basis of price.

(ii) If sealed bids are used, the following requirements apply:

(A) the invitation for bids will be publicly advertised and bids shall be solicited from an adequate number of known suppliers, providing them sufficient time prior to the date set for opening the bids;

(B) The invitation for bids, which will include any specifications and pertinent attachments, shall define the items or services in order for the bidder to properly respond;

(C) All bids will be publicly opened at the time and place prescribed in the invitation for bids;

(D) A firm fixed-price contract award will be made in writing to the lowest responsive and responsible bidder. Where specified in bidding documents, factors such as discounts, transportation cost, and life cycle costs shall be considered in determining which bid is lowest. Payment discounts will only be used to determine the low bid when prior experience indicates that such discounts are usually taken advantage of; and

(E) Any or all bids may be rejected if there is a sound documented reason.

(3) *Procurment by competitive proposals.* The technique of competitive proposals is normally conducted with more than one source submitting an offer, and either a fixed-price or cost-reimbursement type contract is awarded. It is generally used when conditions are not appropriate for the use of sealed bids. If this method is used, the following requirements apply:

(i) Requests for proposals will be publicized and identify all evaluation factors and their relative importance. Any response to publicized requests for proposals shall be honored to the maximum extent practical;

(ii) Proposals will be solicited from an adequate number of qualified sources;

(iii) Grantees and subgrantees will have a method for conducting technical evaluations of the proposals received and for selecting awardees;

(iv) Awards will be made to the responsible firm whose proposal is most advantageous to the program, with price and other factors considered; and

(v) Grantees and subgrantees may use competitive proposal procedures for qualifications-based procurement of architectural/engineering (A/E) professional services whereby competitors' qualifications are evaluated and the most qualified competitor is selected, subject to negotiation of fair and reasonable compensation. The method, where price is not used as a selection factor, can only be used in procurement of A/E professional services. It cannot be used to purchase other types of services through A/E firms are a potential source to perform the proposed effort.

(4) Procurement by noncompetitive proposals is procurement through solicitation of a proposal from only one source, or after solicitation of a number of sources, competition is determined inadequate.

(i) Procurement by noncompetitive proposals may be used only when the award of a contract is infeasible under small purchase procedures, sealed bids or competitive proposals and one of the following circumstances applies:

(A) The item is available only from a single source;

(B) The public exigency or emergency for the requirement will not permit a delay resulting from competitive solicitation;

(C) The awarding agency authorizes noncompetitive proposals; or

(D) After solicitation of a number of sources, competition is determined inadequate.

(ii) Cost analysis, i.e., verifying the proposed cost data, the projections of the data, and the evaluation of the specific elements of costs and profit, is required.

(iii) Grantees and subgrantees may be required to submit the proposed procurement to the awarding agency for pre-award review in accordance with paragraph (g) of this section.

(e) *Contracting with small and minority firms, women's business enterprise and labor surplus area firms.*

(1) The grantee and subgrantee will take all necessary affirmative steps to assure that minority firms, women's business enterprises, and labor surplus area firms are used when possible.

(2) Affirmative steps shall include:

(i) Placing qualified small and minority businesses and women's business enterprises on solicitation lists;

(ii) Assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;

(iii) Dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority business, and women's business enterprises;

(iv) Establishing delivery schedules, where the requirement permits, which encourage participation by small and minority business, and women's business enterprises;

(v) Using the services and assistance of the Small Business Administration, and the Minority Business Development Agency of the Department of Commerce; and

(vi) Requiring the prime contractor, if subcontracts are to be let, to take the affirmative steps listed in paragraphs (e)(2) (i) through (v) of this section.

(f) *Contract cost and price.* (1) Grantees and subgrantees must perform a cost or price analysis in connection with every procurement action including contract modifications. The method and degree of analysis is dependent on the facts surrounding the particular procurement situation, but as a starting point, grantees must make independent estimates before receiving bids or proposals. A cost analysis must be performed when the offeror is required to submit the elements of his estimated cost, e.g., under professional, consulting, and architectural engineering services contracts. A cost analysis will be necessary when adequate price competition is lacking, and for sole source procurements, including contract modifications or change orders, unless price reasonableness can be established on the basis of a catalog or market price of a commercial product sold in substantial quantities to the general public or based on prices set by law or regulation. A price analysis will be used in all other instances to determine the reasonableness of the proposed contract price.

(2) Grantees and subgrantees will negotiate profit as a separate element of the price for each contract in which there is no price competition and in all cases where cost analysis is performed. To establish a fair and reasonable profit, consideration will be given to the complexity of the work to be performed, the risk borne by the contractor, the contractor's investment, the amount of subcontracting, the quality of its record of past performance, and industry profit rates in the surrounding geographical area for similar work.

(3) Costs or prices based on estimated costs for contracts under grants will be allowable only to the extent that costs incurred or cost estimates included in negotiated prices are consistent with Federal cost principles (see § 1403.22). Grantees may reference their own cost principles that comply with the applicable Federal cost principles.

(4) The cost plus a percentage of cost and percentage of constructing cost methods of contracting shall not be used.

(g) *Awarding agency review.* (1) Grantees and subgrantees must make available, upon request of the awarding agency, technical specifications on proposed procurements where the awarding agency believes such review is needed to ensure that the item and/or service specified is the one being proposed for purchase. This review generally will take place prior to the time the specification is incorporated into a solicitation document. However, if the grantee or subgrantee desires to have the review accomplished after a solicitation has been developed, the awarding agency may still review the specifications, with such review usually limited to the technical aspects of the proposed purchase.

(2) Grantees and subgrantees must on request make available for awarding agency pre-award review procurement documents, such as requests for proposals or invitations for bids, independent cost estimates, etc., when:

(i) A grantee's or subgrantee's procurement procedures or operation fails to comply with the procurement standards in this section; or

(ii) The procurement is expected to exceed $25,000 and is to be awarded without competition or only one bid or offer is received in response to a solicitation; or

(iii) The procurement, which is expected to exceed $25,000, specifies a "brand name" product; or

(iv) The proposed award over $25,000 is to be awarded to other than the apparent low bidder under a sealed bid procurement; or

(v) A proposed contract modification changes the scope of a contract or increases the contract amount by more than $25,000.

(3) A grantee or subgrantee will be exempt from the pre-award review in paragraph (g)(2) of this section if the awarding agency determines that its procurement systems comply with the standards of this section.

(i) A grantee or subgrantee may request that its procurement system be reviewed by the awarding agency to determine whether its system meets these standards in order for its system to be certified. Generally, these reviews shall occur where there is a continuous high-dollar funding, and third-party contracts are awarded on a regular basis;

(ii) A grantee or subgrantee may self-certify its procurement system. Such self-certification shall not limit the awarding agency's right to survey the system. Under a self-certification procedure, awarding agencies may wish to rely on written assurances from the grantee or subgrantee that it is complying with these standards. A grantee or subgrantee will cite specific procedures, regulations, standards, etc., as being in compliance with these requirements and have its system available for review.

(h) *Bonding requirements.* For construction or facility improvement contracts or subcontracts exceeding $100,000, the awarding agency may accept the bonding policy and requirements of the grantee or subgrantee provided the awarding agency has made a determination that the awarding agency's interest is adequately protected. If such a determination has not been made, the minimum requirements shall be as follows:

(1) *A bid guarantee from each bidder equivalent to five percent of the bid price.* The "bid guarantee" shall consist of a firm commitment such as a bid bond, certified check, or other negotiable instrument accompanying a bid as assurance that the bidder will, upon acceptance of his bid, execute such contractual documents as may be required within the time specified.

(2) *A performance bond on the part of the contractor for 100 percent of the contract price.* A "performance bond" is one executed in connection with a contract to secure fulfillment of all the contractor's obligations under such contract.

(3) *A payment bond on the part of the contractor for 100 percent of the contract price.* A "payment bond" is one executed in connection with a contract to assure payment as required by law of all persons supplying labor and material in the execution of the work provided for in the contract.

(i) *Contract provisions.* A grantee's and subgrantee's contracts must contain provisions in paragraph (i) of this section. Federal agencies are permitted

to require changes, remedies, changed conditions, access and records retention, suspension of work, and other clauses approved by the Office of Procurement Policy.

(1) Administrative, contractual, or legal remedies in instances where contractors violate or breach contract terms, and provide for such sanctions and penalties as may be appropriate (Contracts other than small purchases).

(2) Termination for cause and for convenience by the grantee or subgrantee including the manner by which it will be effected and the basis for settlement (All contracts in excess of $10,000).

(3) Compliance with Executive Order 11246 of September 24, 1965, entitled "Equal Employment Opportunity," as amended by Executive Order 11375 of October 13, 1967, and as supplemented in Department of Labor regulations (41 CFR chapter 60) (All construction contracts awarded in excess of $10,000 by grantees and their contractors or subgrantees).

(4) Compliance with the Copeland "Anti-Kickback" Act (18 U.S.C. 874) as supplemented in Department of Labor regulations (29 CFR part 3) (All contracts and subgrants for construction or repair).

(5) Compliance with the Davis-Bacon Act (40 U.S.C. 276a to a–7) as supplemented by Department of Labor regulations (29 CFR part 5) (Construction contracts in excess of $2,000 awarded by grantees and subgrantees when required by Federal grant program legislation).

(6) Compliance with Sections 103 and 107 of the Contract Work Hours and Safety Standards Act (40 U.S.C. 327–330) as supplemented by Department of Labor regulations (29 CFR part 5) (Construction contracts awarded by grantees and subgrantees in excess of $2,000, and in excess of $2,500 for other contracts which involve the employment of mechanics or laborers).

(7) Notice of awarding agency requirements and regulations pertaining to reporting.

(8) Notice of awarding agency requirements and regulations pertaining to patent rights with respect to any discovery or invention which arises or is developed in the course of or under such contract.

(9) Awarding agency requirements and regulations pertaining to copyrights and rights in data.

(10) Access by the grantee, the subgrantee, the Federal grantor agency, the Comptroller General of the United States, or any of their duly authorized representatives to any books, documents, papers, and records of the contractor which are directly pertinent to that specific contract for the purpose of making audit, examination, excerpts, and transcriptions.

(11) Retention of all required records for three years after grantees or subgrantees make final payments and all other pending matters are closed.

(12) Compliance with all applicable standards, orders, or requirements issued under section 306 of the Clear Air Act (42 U.S.C. 1857(h)), section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15) (Contracts, subcontracts, and subgrants of amounts in excess of $100,000).

(13) Mandatory standards and policies relating to energy efficiency which are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94–163).

§ 1403.37 Subgrants.

(a) *States.* States shall follow state law and procedures when awarding and administering subgrants (whether on a cost reimbursement or fixed amount basis) of financial assistance to local and Indian tribal governments. States shall:

(1) Ensure that every subgrant includes any clauses required by Federal statute and executive orders and their implementing regulations;

(2) Ensure that subgrantees are aware of requirements imposed upon them by Federal statute and regulation;

(3) Ensure that a provision for compliance with § 1403.42 is placed in every cost reimbursement subgrant; and

(4) Conform any advances of grant funds to subgrantees substantially to the same standards of timing and amount that apply to cash advances by Federal agencies.

(b) *All other grantees.* All other grantees shall follow the provisions of this part which are applicable to awarding agencies when awarding and administering subgrants (whether on a cost reimbursement or fixed amount basis) of financial assistance to local and Indian tribal governments. Grantees shall:

(1) Ensure that every subgrant includes a provision for compliance with this part;

(2) Ensure that every subgrant includes any clauses required by Federal statute and executive orders and their implementing regulations; and

(3) Ensure that subgrantees are aware of requirements imposed upon them by Federal statutes and regulations.

(c) *Exceptions.* By their own terms, certain provisions of this part do not apply to the award and administration of subgrants:

(1) Section 1403.10;

(2) Section 1403.11;

(3) The letter-of-credit procedures specified in Treasury Regulations at 31 CFR part 205, cited in § 1403.21; and

(4) Section 1403.50.

Reports, Records, Retention, and Enforcement

§ 1403.40 Monitoring and reporting program performance.

(a) *Monitoring by grantees.* Grantees are responsible for managing the day-to-day operations of grant and subgrant supported activities. Grantees must monitor grant and subgrant supported activities to assure compliance with applicable Federal requirements and that performance goals are being achieved. Grantee monitoring must cover each program, function or activity.

(b) *Nonconstruction performance reports.* The Federal agency may, if it decides that performance information available from subsequent applications contains sufficient information to meet its programmatic needs, require the grantee to submit a performance report only upon expiration or termination of grant support. Unless waived by the Federal agency this report will be due on the same date as the final Financial Status Report.

(1) Grantees shall submit annual performance reports unless the awarding agency requires quarterly or semi-annual reports. However, performance reports will not be required more frequently than quarterly. Annual reports shall be due 90 days after the grant year, quarterly or semi-annual reports shall be due 30 days after the reporting period. The final performance report will be due 90 days after the expiration or termination of grant support. If a justified request is submitted by a grantee, the Federal agency may extend the due date for any performance report. Additionally, requirements for unnecessary performance reports may be waived by the Federal agency.

(2) Performance reports will contain, for each grant, brief information on the following:

(i) A comparison of actual accomplishments to the objectives established for the period. Where the output of the project can be quantified, a computation of the cost per unit of output may be required if that information will be useful.

(ii) The reasons for slippage if established objectives were not met.

(iii) Additional pertinent information including, when appropriate, analysis

and explanation of cost overruns or high unit costs.

(3) Grantees will not be required to submit more than the original and two copies of performance reports.

(4) Grantees will adhere to the standards in this section in prescribing performance reporting requirements for subgrantees.

(c) *Construction performance reports.* For the most part, on-site technical inspections and certified percentage-of-completion data are relied on heavily by Federal agencies to monitor progress under construction grants and subgrants. The Federal agency will require additional formal performance reports only when considered necessary, and never more frequently than quarterly.

(d) *Significant developments.* Events may occur between the scheduled performance reporting dates which have significant impact upon the grant or subgrant supported activity. In such cases, the grantee must inform the Federal agency as soon as the following types of conditions become known:

(1) Problems, delays, or adverse conditions which will materially impair the ability to meet the objective of the award. This disclosure must include a statement of the action taken, or contemplated, and any assistance needed to resolve the situation.

(2) Favorable developments which enable meeting time schedules and objectives sooner or at less cost than anticipated or producing more beneficial results than originally planned.

(e) Federal agencies may make site visits as warranted by program needs.

(f) *Waivers, extensions.* (1) Federal agencies may waive any performance report required by this part if not needed.

(2) The grantee may waive any performance report from a subgrantee when not needed. The grantee may extend the due date for any performance report from a subgrantee if the grantee will still be able to meet its performance reporting obligations to the Federal agency.

§ 1403.41 Financial reporting.

(a) *General.* (1) Except as provided in paragraphs (a) (2) and (5) of this section, grantees will use only the forms specified in paragraphs (a) through (e) of this section, and such supplementary or other forms as may from time to time be authorized by OMB, for:

(i) Submitting financial reports to Federal agencies, or

(ii) Requesting advances or reimbursements when letters of credit are not used.

(2) Grantees need not apply the forms prescribed in this section in dealing with their subgrantees. However, grantees shall not impose more burdensome requirements on subgrantees.

(3) Grantees shall follow all applicable standard and supplemental Federal agency instructions approved by OMB to the extent required under the Paperwork Reduction Act of 1980 for use in connection with forms specified in paragraphs (b) through (e) of this section. Federal agencies may issue substantive supplementary instructions only with the approval of OMB. Federal agencies may shade out or instruct the grantee to disregard any line item that the Federal agency finds unnecessary for its decision making purposes.

(4) Grantees will not be required to submit more than the original and two copies of forms required under this part.

(5) Federal agencies may provide computer outputs to grantees to expedite or contribute to the accuracy of reporting. Federal agencies may accept the required information from grantees in machine usable format or computer printouts instead of prescribed forms.

(6) Federal agencies may waive any report required by this section if not needed.

(7) Federal agencies may extend the due date of any financial report upon receiving a justified request from a grantee.

(b) *Financial Status Report*—(1) *Form.* Grantees will use Standard Form 269 or 269A, Financial Status Report, to report the status of funds for all nonconstruction grants and for construction grants when required in accordance with paragraph § 1403.41(e)(2)(iii) of this section.

(2) *Accounting basis.* Each grantee will report program outlays and program income on a cash or accrual basis as prescribed by the awarding agency. If the Federal agency requires accrual information and the grantee's accounting records are not normally kept on the accrual basis, the grantee shall not be required to convert its accounting system but shall develop such accrual information through an analysis of the documentation on hand.

(3) *Frequency.* The Federal agency may prescribe the frequency of the report for each project or program. However, the report will not be required more frequently than quarterly. If the Federal agency does not specify the frequency of the report, it will be submitted annually. A final report will be required upon expiration or termination of grant support.

(4) *Due date.* When reports are required on a quarterly or semiannual basis, they will be due 30 days after the reporting period. When required on an annual basis, they will be due 90 days after the grant year. Final reports will be due 90 days after the expiration or termination of grant support.

(c) *Federal Cash Transactions Report*—(1) *Form.* (i) For grants paid by letter of credit, Treasury check advances or electronic transfer of funds, the grantee will submit the Standard Form 272, Federal Cash Transactions Report, and when necessary, its continuation sheet, Standard Form 272a, unless the terms of the award exempt the grantee from this requirement.

(ii) These reports will be used by the Federal agency to monitor cash advanced to grantees and to obtain disbursement or outlay information for each grant from grantees. The format of the report may be adapted as appropriate when reporting is to be accomplished with the assistance of automatic data processing equipment provided that the information to be submitted is not changed in substance.

(2) *Forecasts of Federal cash requirements.* Forecasts of Federal cash requirements may be required in the "Remarks" section of the report.

(3) *Cash in hands of subgrantees.* When considered necessary and feasible by the Federal agency, grantees may be required to report the amount of cash advances in excess of three days' needs in the hands of their subgrantees or contractors and to provide short narrative explanations of actions taken by the grantee to reduce the excess balances.

(4) *Frequency and due date.* Grantees must submit the report no later than 15 working days following the end of each quarter. However, where an advance either by letter of credit or electronic transfer of funds is authorized at an annualized rate of one million dollars or more, the Federal agency may require the report to be submitted within 15 working days following the end of each month.

(d) *Request for advance or reimbursement*—(1) *Advance payments.* Requests for Treasury check advance payments will be submitted on Standard Form 270, Request for Advance or Reimbursement. (This form will not be used for drawdowns under a letter of credit, electronic funds transfer or when Treasury check advance payments are made to the grantee automatically on a predetermined basis.)

(2) *Reimbursements.* Requests for reimbursement under nonconstruction grants will also be submitted on Standard Form 270. (For reimbursement requests under construction grants, see paragraph (e)(1) of this section.)

(3) The frequency for submitting payment requests is treated in § 1403.41(b)(3).

(e) *Outlay report and request for reimbursement for construction programs*—(1) *Grants that support construction activities paid by reimbursement method.* (i) Requests for reimbursement under construction grants will be submitted on Standard Form 271, Outlay Report and Request for Reimbursement for Construction Programs. Federal agencies may, however, prescribe the Request for Advance or Reimbursement form, specified in § 1403.41(d), instead of this form.

(ii) The frequency for submitting reimbursement requests is treated in § 1403.41(b)(3).

(2) *Grants that support construction activities paid by letter of credit, electronic funds transfer or Treasury check advance.* (i) When a construction grant is paid by letter of credit, electronic funds transfer or Treasury check advances, the grantee will report its outlays to the Federal agency using Standard Form 271, Outlay Report and Request for Reimbursement for Construction Programs. The Federal agency will provide any necessary special instruction. However, frequency and due date shall be governed by § 1403.41(b) (3) and (4).

(ii) When a construction grant is paid by Treasury check advances based on periodic requests from the grantee, the advances will be requested on the form specified in § 1403.41(d).

(iii) The Federal agency may substitute the Financial Status Report specified in § 1403.41(b) for the Outlay Report and Request for Reimbursement for Construction Programs.

(3) *Accounting basis.* The accounting basis for the Outlay Report and Request for Reimbursement for Construction Programs shall be governed by § 1403.41(b)(2).

§ 1403.42 Retention and access requirements for records.

(a) *Applicability.* (1) This section applies to all financial and programmatic records, supporting documents, statistical records, and other records of grantees or subgrantees which are:

(i) Required to be maintained by the terms of this Part, program regulations or the grant agreement, or

(ii) Otherwise reasonably considered as pertinent to program regulations or the grant agreement.

(2) This section does not apply to records maintained by contractors or subcontractors. For a requirement to place a provision concerning records in certain kinds of contracts, see § 1403.36(i)(10).

(b) *Length of retention period.* (1) Except as otherwise provided, records must be retained for three years from the starting date specified in paragraph (c) of this section.

(2) If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the 3-year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular 3-year period, whichever is later.

(3) To avoid duplicate recordkeeping, awarding agencies may make special arrangements with grantees and subgrantees to retain any records which are continuously needed for joint use. The awarding agency will request transfer of records to its custody when it determines that the records possess long-term retention value. When the records are transferred to or maintained by the Federal agency, the 3-year retention requirement is not applicable to the grantee or subgrantees.

(c) *Starting date of retention period*—(1) *General.* When grant support is continued or renewed at annual or other intervals, the retention period for the records of each funding period starts on the day the grantee or subgrantee submits to the awarding agency its single or last expenditure report for that period. However, if grant support is continued or renewed quarterly, the retention period for each year's records starts on the day the grantee submits its expenditure report for the last quarter of the Federal fiscal year. In all other cases, the retention period starts on the day the grantee submits its final expenditure report. If an expenditure report has been waived, the retention period starts on the day the report would have been due.

(2) *Real property and equipment records.* The retention period for real property and equipment records starts from the date of the disposition or replacement or transfer at the direction of the awarding agency.

(3) *Records for income transactions after grant or subgrant support.* In some cases grantees must report income after the period of grant support. Where there is such a requirement, the retention period for the records pertaining to the earning of the income starts from the end of the grantee's fiscal year in which the income is earned.

(4) *Indirect cost rate proposals, cost allocations plans, etc.* This paragraph applies to the following types of documents, and their supporting records: indirect cost rate computations or proposals, cost allocation plans, and any similar accounting computations of the rate at which a particular group of costs is chargeable (such as computer usage chargeback rates or composite fringe benefit rates).

(i) *If submitted for negotiation.* If the proposal, plan, or other computation is required to be submitted to the Federal Government (or to the grantee) to form the basis for negotiation of the rate, then the 3-year retention period for its supporting records starts from the date of such submission.

(ii) *If not submitted for negotiation.* If the proposal, plan, or other computation is not required to be submitted to the Federal Government (or to the grantee) for negotiation purposes, then the 3-year retention period for the proposal plan, or computation and its supporting records starts from end of the fiscal year (or other accounting period) covered by the proposal, plan, or other computation.

(d) *Substitution of microfilm.* Copies made by microfilming, photocopying, or similar methods may be substituted for the original records.

(e) *Access to records*—(1) *Records of grantees and subgrantees.* The awarding agency and the Comptroller General of the United States, or any of their authorized representatives, shall have the right of access to any pertinent books, documents, papers, or other records of grantees and subgrantees which are pertinent to the grant, in order to make audits, examinations, excerpts, and transcripts.

(2) *Expiration of right of access.* The rights of access in this section must not be limited to the required retention period but shall last as long as the records are retained.

(f) *Restrictions on public access.* The Federal Freedom of Information Act (5 U.S.C. 552) does not apply to records. Unless required by Federal, State, or local law, grantees and subgrantees are not required to permit public access to their records.

§ 1403.43 Enforcement.

(a) *Remedies for noncompliance.* If a grantee or subgrantee materially fails to comply with any term of an award, whether stated in a Federal statute or regulation, an assurance, in a State plan or application, a notice of award, or elsewhere, the awarding agency may take one or more of the following actions, as appropriate in the circumstances:

(1) Temporarily withhold cash payments pending correction of the deficiency by the grantee or subgrantee or more severe enforcement action by the awarding agency.

(2) Disallow (that is, deny both use of funds and matching credit for) all or part of the cost of the activity or action not in compliance,

(3) Wholly or partly suspend or terminate the current award for the grantee's or subgrantee's program,

(4) Withhold further awards for the program, or

(5) Take other remedies that may be legally available.

(b) *Hearings, appeals.* In taking an enforcement action, the awarding agency will provide the grantee or subgrantee an opportunity for such hearing, appeal, or other administrative proceeding to which the grantee or subgrantee is entitled under any statute or regulation applicable to the action involved.

(c) *Effects of suspension and termination.* Costs of grantee or subgrantee resulting from obligations incurred by the grantee or subgrantee during a suspension or after termination of an award are not allowable unless the awarding agency expressly authorizes them in the notice of suspension or termination or subsequently. Other grantee or subgrantee costs during suspension or after termination which are necessary and not reasonably avoidable are allowable if:

(1) The costs result from obligations which were properly incurred by the grantee or subgrantee before the effective date of suspension or termination, are not in anticipation of it, and, in the case of a termination, are noncancellable, and,

(2) The costs would be allowable if the award were not suspended or expired normally at the end of the funding period in which the termination takes effect.

(d) *Relationship to Debarment and Suspension.* The enforcement remedies identified in this section, including suspension and termination, do not preclude grantee or subgrantee from being subject to "Debarment and Suspension" under E.O. 12549 (see § 1403.35).

§ 1403.44 Termination for convenience.

Except as provided in § 1403.43 awards may be terminated in whole or in part only as follows:

(a) By the awarding agency with the consent of the grantee or subgrantee in which case the two parties shall agree upon the termination conditions, including the effective date and in the case of partial termination, the portion to be terminated, or

(b) By the grantee or subgrantee upon written notification to the awarding agency, setting forth the reasons for such termination, the effective date, and in the case of partial termination, the portion to be terminated. However, if, in the case of a partial termination, the awarding agency determines that the remaining portion of the award will not accomplish the purposes for which the award was made, the awarding agency may terminate the award in its entirety under either § 1403.43 or paragraph (a) of this section.

Subpart D—After-The-Grant Requirements

§ 1403.50 Closeout.

(a) *General.* The Federal agency will close out the award when it determines that all applicable administrative actions and all required work of the grant has been completed.

(b) *Reports.* Within 90 days after the expiration or termination of the grant, the grantee must submit all financial, performance, and other reports required as a condition of the grant. Upon request by the grantee, Federal agencies may extend this time frame. These may include but are not limited to:

(1) Final performance or progress report.

(2) Financial Status Report (SF 269) or Outlay Report and Request for Reimbursement for Construction Programs (SF–271) (as applicable).

(3) Final request for payment (SF–270) (if applicable).

(4) Invention disclosure (if applicable).

(5) Federally-owned property report: In accordance with § 1403.32(f), a grantee must submit an inventory of all federally owned property (as distinct from property acquired with grant funds) for which it is accountable and request disposition instructions from the Federal agency of property no longer needed.

(c) *Cost adjustment.* The Federal agency will, within 90 days after receipt of reports in paragraph (b) of this section, make upward or downward adjustments to the allowable costs.

(d) *Cash adjustments.* (1) The Federal agency will make prompt payment to the grantee for allowable reimbursable costs.

(2) The grantee must immediately refund to the Federal agency any balance of unobligated (unencumbered) cash advanced that is not authorized to be retained for use on other grants.

§ 1403.51 Later disallowances and adjustments.

The closeout of a grant does not affect:

(a) The Federal agency's right to disallow costs and recover funds on the basis of a later audit or other review;

(b) The grantee's obligation to return any funds due as a result of later refunds, corrections, or other transactions;

(c) Records retention as required in § 1403.42;

(d) Property management requirements in § 1403.31 and § 1403.32; and

(e) Audit requirements in § 1403.26.

§ 1403.52 Collection of amounts due.

(a) Any funds paid to a grantee in excess of the amount to which the grantee is finally determined to be entitled under the terms of the award constitute a debt to the Federal Government. If not paid within a reasonable period after demand, the Federal agency may reduce the debt by:

(1) Making an administrative offset against other requests for reimbursement,

(2) Withholding advance payments otherwise due to the grantee, or

(3) Other action permitted by law.

(b) Except where otherwise provided by statutes or regulations, the Federal agency will charge interest on an overdue debt in accordance with the Federal Claims Collection Standards (4 CFR Ch. II). The date from which interest is computed is not extended by litigation or the filing of any form of appeal.

Subpart E—Entitlement [Reserved]

Appendix A to Part 1403—OMB Circular A–128, "Audits of State and Local Governments"

Circular No. A–128
April 12, 1985.

To the Heads of Executive Departments and Establishments

Subject: Audits of State and Local Governments.

1. Purpose. This Circular is issued pursuant to the Single Audit Act of 1984, Pub. L. 98–502. It establishes audit requirements for State and local governments that receive Federal aid, and defines Federal responsibilities for implementing and monitoring those requirements.

2. Supersession. The Circular supersedes Attachment P, "Audit Requirements," of Circular A–102, "Uniform requirements for grants to State and local governments."

3. Background. The Single Audit Act builds upon earlier efforts to improve audits of Federal aid programs. The Act requires State or local governments that receive $100,000 or more a year in Federal funds to have an audit made for that year. Section 7505 of the Act requires the Director of the Office of Management and Budget to prescribe policies, procedures and guidelines to implement the Act. It specifies that the Director shall designate "cognizant" Federal agencies, determine criteria for making appropriate charges to federal programs for

the cost of audits, and provide procedures to assure that small firms or firms owned and controlled by disadvantaged individuals have the opportunity to participate in contracts for single audits.

4. Policy. The Single Audit Act requires the following:

a. State or local governments that receive $100,000 or more a year in Federal financial assistance shall have an audit made in accordance with this Circular.

b. State or local governments that receive between $25,000 and $100,000 a year shall have an audit made in accordance with this Circular, or in accordance with Federal laws and regulations governing the programs they participate in.

c. State or local governments that receive less than $25,000 a year shall be exempt from compliance with the Act and other Federal audit requirements. These State and local governments shall be governed by audit requirements prescribed by State or local law or regulation.

d. Nothing in this paragraph exempts State or local governments from maintaining records of Federal financial assistance or from providing access to such records to Federal agencies, as provided for in Federal law or in Circular A-102, "Uniform requirements for grants to state or local governments."

5. Definitions. For the purposes of this Circular the following definitions from the Single Audit Act apply:

a. *Cognizant agency* means the Federal agency assigned by the Office of Management and Budget to carry out the responsibilities described in paragraph 11 of this Circular.

b. *Federal financial assistance* means assistance provided by a Federal agency in the form of grants, contracts, cooperative agreements, loans, loan guarantees, property, interest subsidies, insurance, or direct appropriations, but does not include direct Federal cash assistance to individuals. It includes awards received directly from Federal agencies, or indirectly through other units of States and local governments.

c. *Federal agency* has the same meaning as the term "agency" in section 551(1) of Title 5, United States Code.

d. *Generally accepted accounting principles* has the meaning specified in the generally accepted government auditing standards.

e. *Generally accepted government auditing standards* means the Standards For Audit of Government Organizations, Programs, Activities, and Functions, developed by the Comptroller General, dated February 27, 1981.

f. *Independent auditor* means:

(1) A State or local government auditor who meets the independence standards specified in generally accepted government auditing standards; or

(2) A public accountant who meets such independence standards.

g. *Internal controls* means the plan of organization and methods and procedures adopted by management to ensure that:

(1) Resource use is consistent with laws, regulations, and policies;

(2) Resources are safeguarded against waste, loss, and misuse; and

(3) Reliable data are obtained, maintained, and fairly disclosed in reports.

h. *Indian tribe* means any Indian tribe, band, nations, or other organized group or community, including any Alaskan Native village or regional or village corporations (as defined in, or established under, the Alaskan Native Claims Settlement Act) that is recognized by the United States as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

i. *Local government* means any unit of local government within a State, including a county, a borough, municipality, city, town, township, parish, local public authority, special district, school district, intrastate district, council of government, and any other instrumentality of local government.

j. *Major Federal Assistance Program*, as defined by Pub. L. 98-502, is described in the Attachment to this Circular.

k. *Public accountants* means those individuals who meet the qualification standards included in generally accepted government auditing standards for personnel performing government audits.

l. *State* means any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, any instrumentality thereof, and any multi-State, regional, or interstate entity that has governmental functions and any Indian tribe.

m. *Subrecipient* means any person or government department, agency, or establishment that receives Federal financial assistance to carry out a program through a State or local government, but does not include an individual that is a beneficiary of such a program. A subrecipient may also be a direct recipient of Federal financial assistance.

6. Scope of audit. The Single Act provides that:

a. The audit shall be made by an independent auditor in accordance with generally accepted government auditing standards covering financial and compliance audits.

b. The audit shall cover the entire operations of a State or local government or, at the option of that government, it may cover departments, agencies or establishments that received, expended, or otherwise administered Federal financial assistance during the year. However, if a State or local government receives $25,000 or more in General Revenue Sharing Funds in a fiscal year, it shall have an audit of its entire operations. A series of audits of individual departments, agencies, and establishments for the same fiscal year may be considered a single audit.

c. Public hospitals and public colleges and universities may be excluded from State and local audits and the requirements of this Circular. However, if such entities are excluded, audits of these entities shall be made in accordance with statutory requirements and the provisions of Circular A-110, "Uniform requirements for grants to universities, hospitals, and other nonprofit organizations."

d. The auditor shall determine whether:

(1) The financial statements of the government, department, agency or establishment present fairly its financial position and the results of its financial operations in accordance with generally accepted accounting principles;

(2) The organization has internal accounting and other control systems to provide reasonable assurance that it is managing Federal financial assistance programs in compliance with applicable laws and regulations; and

(3) The organization has complied with laws and regulations that may have material effect on its financial statements and on each major Federal assistance program.

7. Frequency of audit. Audits shall be made annually unless the State or local government has, by January 1, 1987, a constitutional or statutory requirement for less frequent audits. For those governments, the cognizant agency shall permit biennial audits, covering both years, if the government so requests. It shall also honor requests for biennial audits by governments that have an administrative policy calling for audits less frequent than annual, but only for fiscal years beginning before January 1, 1987.

8. Internal control and compliance reviews. The Single Audit Act requires that the independent auditor determine and report on whether the organization has internal control systems to provide reasonable assurance that it is managing Federal assistance programs in compliance with applicable laws and regulations.

a. Internal control review. In order to provide this assurance the auditor must make a study and evaluation of internal control systems used in administering Federal assistance programs. The study and evaluation must be made whether or not the auditor intends to place reliance on such systems. As part of this review, the auditor shall:

(1) Test whether these internal control systems are functioning in accordance with prescribed procedures.

(2) Examine the recipient's system for monitoring subrecipients and obtaining and acting on subrecipient audit reports.

b. Compliance review. The law also requires the auditor to determine whether the organization has complied with laws and regulations that may have a material effect on each major Federal assistance program.

(1) In order to determine which major programs are to be tested for compliance, State and local governments shall identify in their accounts all Federal funds received and expended and the programs under which they were received. This shall include funds received directly from Federal agencies and through other State and local governments.

(2) The review must include the selection and testing of a representative number of charges from each major Federal assistance program. The selection and testing of transactions shall be based on the auditor's professional judgment considering such factors as the amount of expenditures for the program and the individual awards; the newness of the program or changes in its conditions; prior experience with the

program, particularly as revealed in audits and other evaluations (e.g., inspections program reviews); the extent to which the program is carried out through subrecipients; the extent to which the program contracts for goods or services; the level to which the program is already subject to program reviews or other forms of independent oversight; the adequacy of the controls for ensuring compliance; the exception of adherence or lack of adherence to the applicable laws and regulations; and the potential impact of adverse findings.

(a) In making the test of transactions, the auditor shall determine whether:

—The amounts reported as expenditures were for allowable services, and
—The records show that those who received services or benefits were eligible to receive them.

(b) In addition to transaction testing, the auditor shall determine whether:

—Matching requirements, levels of effort and earmarking limitations were met,
—Federal financial reports and claims for advances and reimbursements contain information that is supported by the books and records from which the basic financial statements have been prepared, and
—Amounts claimed or used for matching were determined in accordance with OMB Circular A–87, "Cost principles for State and local governments," and Attachment F of Circular A–102, "Uniform requirements for grants to State and local governments."

(c) The principal compliance requirements of the largest Federal aid programs may be ascertained by referring to the Compliance Supplement for Single Audits of State and Local Governments, issued by OMB and available from the Government Printing Office. For those programs not covered in the Compliance Supplement, the auditor may ascertain compliance requirements by researching the statutes, regulations, and agreements governing individual programs.

(3) Transactions related to other Federal assistance programs that are selected in connection with examinations of financial statements and evaluations of internal controls shall be tested for compliance with Federal laws and regulations that apply to such transactions.

9. Subrecipients. State or local governments that receive Federal financial assistance and provide $25,000 or more of it in a fiscal year to a subrecipient shall:

a. Determine whether State or local subrecipients have met the audit requirements of this Circular and whether subrecipients covered by Circular A–110, "Uniform requirements for grants to universities, hospitals, and other nonprofit organizations," have met that requirement;

b. Determine whether the subrecipient spent Federal assistance funds provided in accordance with applicable laws and regulations. This may be accomplished by reviewing an audit of the subrecipient made in accordance with this Circular, Circular A–110, or through other means (e.g., program reviews) if the subrecipient has not yet had such an audit;

c. Ensure that appropriate corrective action is taken within six months after receipt of the audit report in instances of noncompliance with Federal laws and regulations;

d. Consider whether subrecipient audits necessitate adjustment of the recipient's own records; and

e. Require each subrecipient to permit independent auditors to have access to the records and financial statements as necessary to comply with this Circular.

10. Relation to other audit requirements. The Single Audit Act provides that an audit made in accordance with this Circular shall be in lieu of any financial or financial compliance audit required under individual Federal assistance programs. To the extent that a single audit provides Federal agencies with information and assurances they need to carry out their overall responsibilities, they shall rely upon and use such information. However, a Federal agency shall make any additional audits which are necessary to carry out its responsibilities under Federal law and regulation. Any additional Federal audit effort shall be planned and carried out in such a way as to avoid duplication.

a. The provisions of this Circular do not limit the authority of Federal agencies to make, or contract for audits and evaluations of Federal financial assistance programs, nor do they limit the authority of any Federal agency Inspector General or other Federal audit official.

b. The provisions of this Circular do not authorize any State or local government or subrecipient thereof to constrain Federal agencies, in any manner, from carrying out additional audits.

c. A Federal agency that makes or contracts for audits in addition to the audits made by recipients pursuant to this Circular shall, consistent with other applicable laws and regulations, arrange for funding the cost of such additional audits. Such additional audits include economy and efficiency audits, program results audits, and program evaluations.

11. Cognizant agency responsibilities. The Single Audit Act provides for cognizant Federal agencies to oversee the implementation of this Circular.

a. The Office of Management and Budget will assign cognizant agencies for States and their subdivisions and larger local governments and their subdivisions. Other Federal agencies may participate with an assigned cognizant agency, in order to fulfill the cognizance responsibilities. Smaller governments not assigned a cognizant agency will be under the general oversight of the Federal agency that provides them the most funds whether directly or indirectly.

b. A cognizant agency shall have the following responsibilities:

(1) Ensure that audits are made and reports are received in a timely manner and in accordance with the requirements of this Circular.

(2) Provide technical advice and liaison to State and local governments and independent auditors.

(3) Obtain or make quality control reviews of selected audits made by non-Federal audit organizations, and provide the results, when appropriate, to other interested organizations.

(4) Promptly inform other affected Federal agencies and appropriate Federal law enforcement officials of any reported illegal acts or irregularities. They should also inform State or local law enforcement and prosecuting authorities, if not advised by the recipient, of any violation of law within their jurisdiction.

(5) Advise the recipient of audits that have been found not to have met the requirements set forth in this Circular. In such instances, the recipient will be expected to work with the auditor to take corrective action. If corrective action is not taken, the cognizant agency shall notify the recipient and Federal awarding agencies of the facts and make recommendations for followup action. Major inadequacies or repetitive substandard performance of independent auditors shall be referred to appropriate professional bodies for disciplinary action.

(6) Coordinate, to the extent practicable, audits made by or for Federal agencies that are in addition to the audits made pursuant to this Circular; so that the additional audits build upon such audits.

(7) Oversee the resolution of audit findings that affect the programs of more than one agency.

12. Illegal acts or irregularities. If the auditor becomes aware of illegal acts or other irregularities, prompt notice shall be given to recipient management officials above the level of involvement. (See also paragraph 13(a)(3) below for the auditor's reporting responsibilities.) The recipient, in turn, shall promptly notify the cognizant agency of the illegal acts or irregularities and of proposed and actual actions, if any. Illegal acts and irregularities include such matters as conflicts of interest, falsification of records or reports, and misappropriations of funds or other assets.

13. Audit reports. Audit reports must be prepared at the completion of the audit. Reports serve many needs of State and local governments as well as meeting the requirements of the Single Audit Act.

a. The audit report shall state that the audit was made in accordance with the provisions of this Circular. The report shall be made up of at least:

(1) The auditor's report on financial statements and on a schedule of Federal assistance; the financial statements; and a schedule of Federal assistance, showing the total expenditures for each Federal assistance program as identified in the Catalog of Federal Domestic Assistance. Federal programs or grants that have not been assigned a catalog number shall be identified under the caption "other Federal assistance."

(2) The auditor's report on the study and evaluation of internal control systems must identify the organization's significant internal accounting controls, and those controls designed to provide reasonable assurance that Federal programs are being managed in compliance with laws and regulations. It must also identify the controls that were evaluated, the controls that were not evaluated, and the material weaknesses identified as a result of the evaluation.

(3) The auditor's report on compliance containing:

—A statement of positive assurance with respect to those items tested for compliance, including compliance with law and regulations pertaining to financial reports and claims for advances and reimbursements;
—Negative assurance on those items not tested;
—A summary of all instances of noncompliance; and
—An identification of total amounts questioned, if any, for each Federal assistance award, as a result of noncompliance.

b. The three parts of the audit report may be bound

b. The three parts of the audit report may be found into a single report, or presented at the same time as separate documents.

c. All fraud abuse, or illegal acts or indications of such acts, including all questioned costs found as the result of these acts that auditors become aware of, should normally be covered in a separate written report submitted in accordance with paragraph 13f.

d. In addition to the audit report, the recipient shall provide comments on the findings and recommendations in the report, including a plan for corrective action taken or planned and comments on the status of corrective action taken on prior findings. If corrective action is not necessary, a statement describing the reason it is not should accompany the audit report.

e. The reports shall be made available by the State or local government for public inspection within 30 days after the completion of the audit.

f. In accordance with generally accepted government audit standards, reports shall be submitted by the auditor to the organization audited and to those requiring or arranging for the audit. In addition, the recipient shall submit copies of the reports to each Federal department or agency that provided Federal assistance funds to the recipient. Subrecipients shall submit copies to recipients that provided them Federal assistance funds. The reports shall be sent within 30 days after the completion of the audit, but no later than one year after the end of the audit period unless a longer period is agreed to with the cognizant agency.

g. Recipients of more than $100,000 in Federal funds shall submit one copy of the audit report within 30 days after issuance to a central clearinghouse to be designated by the Office of Management and Budget. The clearinghouse will keep completed audits on file and follow up with State and local governments that have not submitted required audit reports.

h. Recipients shall keep audit reports on file for three years from their issuance.

14. Audit Resolution. As provided in paragraph 11, the cognizant agency shall be responsible for monitoring the resolution of audit findings that affect the programs of more than one Federal agency. Resolution of findings that relate to the programs of a single Federal agency will be the responsibility of the recipient and that agency. Alternate arrangements may be made on a case-by-case basis by agreement among the agencies concerned.

Resolution shall be made within six months after receipt of the report by the Federal departments and agencies. Corrective action should proceed as rapidly as possible.

15. Audit workpapers and reports. Workpapers and reports shall be retained for a minimum of three years from the date of the audit report, unless the auditor is notified in writing by the cognizant agency to extend the retention period. Audit workpapers shall be made available upon request to the cognizant agency or its designee or the General Accounting Office, at the completion of the audit.

16. Audit Costs. The cost of audits made in accordance with the provisions of this Circular are allowable charges to Federal assistance programs.

a. The charges may be considered a direct cost or an allocated indirect cost, determined in accordance with the provision of Circular A–87, "Cost principles for State and local governments."

b. Generally, the percentage of costs charged to Federal assistance programs for a single audit shall not exceed the percentage that Federal funds expended represent of total funds expended by the recipient during the fiscal year. The percentage may be exceeded, however, if appropriate documentation demonstrates higher actual cost.

17. Sanctions. The Single Audit Act provides that no cost may be charged to Federal assistance programs for audits required by the Act that are not made in accordance with this Circular. In cases of continued inability or unwillingness to have a proper audit, Federal agencies must consider other appropriate sanctions including:
—Withhodling a percentage of assistance payments until the audit is completed satisfactorily,
—Withholding or disallowing overhead costs, and
—Suspending the Federal assistance agreement until the audit is made.

18. Auditor Selection. In arranging for audit services State and local governments shall follow the procurement standards prescribed by Attachment O of Circular A–102, "Uniform requirements for grants to State and local governments." The standards provide that while recipients are encouraged to enter into intergovernmental agreements for audit and other services, analysis should be made to determine whether it would be more economical to purchase the services from private firms. In instances where use of such intergovernmental agreements are required by State statutes (e.g., audit services) these statutes will take precedence.

19. Small and Minority Audit Firms. Small audit firms and audit firms owned and controlled by socially and economically disadvantaged individuals shall have the maximum practicable opportunity to participate in contracts awarded to fulfill the requirements of this Circular. Recipients of Federal assistance shall take the following steps to further this goal:

a. Assure that small audit firms and audit firms owned and controlled by socially and economically disadvantaged individuals are used to the fullest extent practicable.

b. Make information on forthcoming opportunities available and arrange time frames for the audit so as to encourage and facilitate participation by small audit firms and audit firms owned and controlled by socially and economically disadvantaged individuals.

c. Consider in the contract process whether firms competing for larger audits intend to subcontract with small audit firms and audit firms owned and controlled by socially and economically disadvantaged individuals.

d. Encourage contracting with small audit firms or audit firms owned and controlled by socially and economically disadvantaged individuals which have traditionally audited government programs and, in such cases where this is not possible, assure that these firms are given consideration for audit subcontracting opportunities.

e. Encourage contracting with consortiums of small audit firms as described in paragraph (a) above when a contract is too large for an individual small audit firm or audit firm owned and controlled by socially and economically disadvantaged individuals.

f. Use the services and assistance, as appropriate, of such organizations as the Small Business Administration in the solicitation and utilization of small audit firms or audit firms owned and controlled by socially and economically disadvantaged individuals.

20. Reporting. Each Federal agency will report to the Director of OMB on or before March 1, 1987, and annually thereafter on the effectiveness of State and local governments in carrying out the provisions of this Circular The report must identify each State or local government or Indian tribe that, in the opinion of the agency, is failing to comply with Circular.

21. Regulations. Each Federal agency shall include the provisions of this Circular in its regulations implementing the Single Audit Act.

22. Effective date. This Circular is effective upon publication and shall apply to fiscal years of State and local governments that begin after December 31, 1984. Earlier implementation is encouraged. However, until it is implemented, the audit provisions of Attachment P to Circular A–102 shall continue to be observed.

23. Inquiries. All questions or inquiries should be addressed to Financial Management Division, Office of Management and Budget, telephone number (202) 395–3993.

24. Sunset review date. This Circular shall have an independent policy review to ascertain its effectiveness three years from the date of issuance.

David A. Stockman,

Director.

Circular A–128 Attachment

Definition of Major Program as Provided in Pub. L. 98–502

"Major Federal Assistance Program," for State and local governments having Federal assistance expenditures between $100,000 and $100,000,000, means any program for which Federal expenditures during the applicable year exceed the larger of $300,000 or 3 percent of such total expenditures.

Where total expenditures of Federal assistance exceed $100,000,000, the following criteria apply:

Total expenditures of Federal financial assistance for all programs		Major Federal assistance program means any program that exceeds
More than	But less than	
$100 million	1 billion	$3 million
1 billion	2 billion	4 million
2 billion	3 billion	7 million
3 billion	4 billion	10 million
4 billion	5 billion	13 million
5 billion	6 billion	16 million
6 billion	7 billion	19 million
Over 7 billion	-	20 million

Bob Martinez,

Director.

[FR Doc. 92-27962 Filed 11-23-92; 8:45 am]

BILLING CODE 3180-02-M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of Assistant Secretary for Housing-Federal Housing Commissioner

24 CFR Part 207

[Docket No. R-92-1594; FR-2949-F-01]

Debenture Lock Agreements for Payment of FHA Insurance Claims

AGENCY: Office of the Assistant Secretary for Housing-Federal Housing Commissioners, HUD.

ACTION: Final rule.

SUMMARY: This rule reflects the Department's legal authority to agree, prior to the filing of a claim for insurance benefits under certain multifamily, hospital and health facilities programs, to pay its insurance benefits in debentures.

FHA-insured mortgages for hospitals and other health facilities are usually funded by the issuance of tax-exempt bonds. Multifamily rental projects can also be insured in this manner. In situations where there is a subsequent refunding of the bond issuance from a high interest rate to a lower interest rate, the principal amount of the refunding bonds can exceed the principal amount of the bonds refunded. However, by refunding the bonds prior to maturity and reducing the mortgage interest rate to correspond to the lower interest rate on the new bonds, there are potential savings to the mortgagor, issuer and/or the Federal government. In some of those situations it may be advantageous for the Department to agree to a "debenture lock", that is an agreement that if a default occurs while the principal amount of the refunding bonds outstanding exceeds the principal amount of the mortgage, HUD will pay any subsequent insurance claim in debentures rather than cash. The purpose of this rule is to reflect the Department's legal authority to enter into these debenture lock agreements.

EFFECTIVE DATE: December 24, 1992.

FOR FURTHER INFORMATION CONTACT: Lisa A. Bolden, Special Assistant to the Assistant Secretary for Housing-Federal Housing Commissioner, Department of Housing and Urban Development, 451 Seventh Street SW., Washington, DC 20410, voice: (202) 708-2004. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: Since 1987, the Department has agreed to a "debenture lock" with the approval of 32 hospital bond refundings and one nursing home refunding where the mortgages insured under section 242 and 232 respectively of the National Housing Act were involved. (Although not involved in this regulation change, the Department has also approved debenture locks for refundings involving section 8 subsidies for 34 projects with mortgages insured under section 221.)

The instances for which debenture locks have been approved have all been ones in which the Federal Government was paying, either through subsidies or reimbursements (e.g. medicare), all or a substantial portion of bond debt service and the Federal Government would realize substantial savings by a refunding of the outstanding bonds at a lower interest rate.

24 CFR 207.259(a) currently requires, in pertinent part, that the Commissioner determine the method of payment (cash, debentures, or a combination) at the time of payment of a claim on rental housing mortgages insured under part 207. This regulation is incorporated by reference into the regulations for a number of other multifamily FHA programs, including the section 232 program for nursing homes and the section 242 program for hospitals. In a debenture lock transaction, HUD agrees, at the time of the bond refunding, that if a mortgage insurance claim is subsequently filed, HUD will pay insurance benefits in the form of debentures. The regulatory change made by this rule explicitly establishes HUD's authority to enter into debenture lock agreements by specifically permitting HUD to determine the method of payment of insurance claims at or prior to the time of payment. The change is effected by a revision to 24 CFR 207.259(a). It is intended to have retroactive effect upon prior debenture lock transactions, as well as authorize HUD to review and, where appropriate, approve prospective debenture lock transactions in all the multifamily and health care mortgage insurance programs covered by the aforesaid regulation.

The Department also has approved debenture locks for refundings involving section 8 subsidies for projects with mortgages insured under section 221. A similar regulatory clarification covering such projects is not necessary, since under 24 CFR 221.762(a), it is at the sole option of the mortgagee whether payment of the insurance claim on section 221 mortgages will be in cash or debentures.

The following is an illustration of how a debenture lock agreement operates.

FHA-insured mortgages for hospitals are usually funded by issuance of tax-exempt bonds. In situations where there is a subsequent refunding of the bond issuance from a high interest rate to a lower interest rate, the principal amount of the refunding bonds can exceed the principal amount of the bonds refunded. However, by refunding the bonds prior to maturity and reducing the mortgage interest rate to correspond to the lower interest rate on the new bonds, there are potential savings to the hospital and/or the Federal government.

For example, for hospitals that are reimbursed by Medicare for their capital expenses under the "hold harmless" provisions of the prospective payment methodology set forth in 42 CFR parts 412 and 413, (i.e. hospitals with a hospital-specific capital-per-discharge rate higher than the Federal rate), some of the reduction in monthly interest expense for Old Capital (as defined in the regulation) would result in a reduction in Medicare capital reimbursement. In such cases, the savings would accrue to both the hospital and the Federal government.

For hospitals that are subject to the prospective payment methodology (i.e., hospitals with a hospital-specific capital-per-discharge rate lower than the Federal rate), the savings would accrue to the hospital, since their level of Medicare capital reimbursement would not be reduced as a result of the interest expense reduction caused by the debenture lock refunding. Such savings to hospitals should result in an increased quality and availability of health care.

When the Department agrees to a "debenture lock," it agrees that if a default occurs while the principal amount of the refunding bonds outstanding exceeds the principal amount of the mortgage, HUD will pay any subsequent insurance claim in

debentures rather than in cash. The cash flow on the debentures under these circumstances should be sufficient to pay off in full all bonds at or prior to maturity. In some instances HUD could incur a cash management loss if a default and claim were to occur during the early years of a debenture lock agreement. In other words, the interest rate on the debenture could be higher then the cost of borrowing from the Treasury. Therefore the cost to HUD of making an immediate cash pay out on the mortgage insurance claim would be less than the payment of interest and principal over 20 years in connection with the debentures. However, over a reasonable period of time, a debenture lock would, in all likelihood, reduce the Government's exposure in the event of a subsequent default and claim. This is because after several years, a lower principal amount of debentures is required to pay off the bonds than if HUD's claim payment covered the full unpaid mortgage principal. By reducing the government's exposure on outstanding insured hospital loans, debenture lock refundings may well result in potential savings to the FHA General Insurance Fund.

This rule effects no substantive changes in current HUD policies, and no foreseeable benefit is to be gained from public comment. It is, therefore, being put into effect by means of a final rule.

Other Matters

Executive Order 12612, Federalism

The General Counsel, as the Designated Official under section 6(a) of Executive Order 12612, *Federalism*, has determined that the policies contained in this rule will not have Federalism implications when implemented and, thus, are not subject to review under the Order. The rule reflects no substantive change in current HUD policies.

Executive Order 12606, The Family

The General Counsel, as the Designated Official under Executive Order 12606, has determined that this rule would not have potential significant impact on family formation, maintenance, and general well-being, and, thus, is not subject to review under the Order. The rule effects no substantive changes in current HUD policies.

Executive Order 12291, on Federal Regulations

This rule does not constitute a "major rule" as that term is defined in section 1(d) of the Executive Order 12291 on Federal Regulations issued by the President on February 17, 1981. An analysis of the rule indicates that it does not (1) have an annual effect on the economy of $100 million or more; (2) cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or (3) have a significant adverse effect on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Environmental Review

In accordance with 24 CFR 50.20(1) of the HUD regulations, the policies and procedures set forth in this document relate only to the statutorily required establishment and review of interest rates and similar rate and cost determinations which do not constitute a development decision that affects the physical condition of specific project areas or building sites and therefore are categorically excluded from the requirements of the National Environmental Policy Act.

Regulatory Flexibility

Under the Regulatory Flexibility Act (5 U.S.C. 605(b), the Undersigned hereby certifies that this rule does not have a significant economic impact on a substantial number of small entities. The rule effects to substantive changes in current HUD policies.

Semiannual Agenda

This rule was listed as item 1432 in the Department's Semiannual Agenda of Regulations published on November 3, 1992 (57 FR 51396, 51420) under Executive Order 12291 and the Regulatory Flexibility Act.

The Catalog of Federal Domestic Assistance program numbers is 14.134.

List of Subjects in 24 CFR Part 207

Manufactured homes, Mortgage insurance, Reporting and recordkeeping requirements.

PART 207—[AMENDED]

Accordingly, 24 CFR part 207 is amended as follows:

1. The authority citation for 24 CFR part 207 continues to read as follows:

Authority: 12 U.S.C. 1701z–11(e), 1713, and 1715b; 42 U.S.C. 3535(d). Sections 207.258 and 207.258b are also issued under 12 U.S.C. 1701z–11(e).

2. In § 207.259, paragraph (a) introductory text is revised to read as follows:

§ 207.259 Insurance benefits.

(a) *Method of payment.* Upon either an assignment of the mortgage to the Commissioner or a conveyance of the property to him in accordance with requirements in § 207.258, payment of an insurance claim shall be made in cash, in debentures, or in a combination of both, as determined by the Commissioner either at, or prior to, the time of payment, except where the mortgage is insured pursuant to:

* * * * *

Dated: November 18, 1992.

Arthur J. Hill,

Assistant Secretary for Housing-Federal Housing Commissioner.

[FR Doc. 92–28383 Filed 11–23–92; 8:45 am]

BILLING CODE 4210–27–M

POSTAL SERVICE

39 CFR Part 111

Mailability of Sharps and Other Medical Devices

AGENCY: Postal Service.

ACTION: Amendment to final rule.

SUMMARY: In response to further comments from mailers, additional changes are being made pertaining to the final rule titled "Mailability of Used Sharps and Other Medical Devices", dated June 30, 1992 (52 FR 29028). The Postal Service has reevaluated the classification of this type of material and determined that it was incorrect. Therefore, the labeling and marking requirements are being changed. However, the new specifications for the packaging of used sharps and other medical devices are not changed by this amendment.

EFFECTIVE DATE: March 21, 1993.

FOR FURTHER INFORMATION CONTACT: Earl Hohbein. (202) 268–5309.

SUPPLEMENTARY INFORMATION: Current requirements specify that used sharps and similar material must be mailed as First-Class or Priority Mail. Since First-Class or Priority Mail may be transported by aircraft, it is important that the labels and markings on this material provide adequate notice of the contents to persons handling the mail, without imposing unnecessary preparation requirements and paperwork on mailers. The Postal Service has been advised that requiring the use of an "Infectious Substance" label and markings on packages of used sharps imposes such unnecessary requirements on mailers, and in addition unduly complicates cargo handling

procedures for airline employees, without enhancing the protection of the health and safety of those employees that handle this kind of material. The Postal Service has accordingly determined that it would be appropriate, and provide adequate notice to concerned personnel, to substitute the use of the "International Biohazard Symbol" label.

In conformity with this decision, the Postal Service has also decided to rescind the related requirements published on September 21, 1992 (57 FR 43403), pertaining to the use of a shipper's declaration for dangerous goods (in addition to the required manifest) showing the proper shipping name (49 CFR 172.202(a)(1)), the hazard class or division (40 CFR 172.202(a)(2)), and the identification number for the material (49 CFR 172.202(a)(3)). In view of this change, we are also amending content requirements for the four-part manifest described in DMM Exhibit 124.385h.

Although exempt from the notice and comment requirements of the Administrative Procedures Act (5 U.S.C. 553)(b) and (e), the Postal Service welcomes comments on the revised rule.

After careful consideration of the comments received after publishing the final rule and the amendment to the final rule, the Postal Service adopts the following amendments to part 124 of the Domestic Mail Manual, which is incorporated by reference in the Code of Federal Regulations. See 39 CFR part 111.

List of Subjects in 39 CFR Part III

Administrative practice and procedure, Postal Service.

PART 111—[AMENDED]

1. The authority citation for 39 CFR part 111 continues to read as follows:

Authority: 5 U.S.C. 552(a); 39 U.S.C. 101, 401, 403, 404, 3001–3011, 3201–3219, 3403–3406, 3621, 5001.

2. Part 124 of the Domestic Mail Manual is amended to read as follows:

124 NONMAILABLE MATTER-ARTICLES AND SUBSTANCES; SPECIAL MAILING RULES

* * * * *

124.385 Sharps (Effective March 21, 1993, Except Where Noted)

a. A parcel containing the types of used materials defined in 124.382e is nonmailable unless it bears the "International Biohazard Symbol" on a label with either a fluorescent orange or fluorescent red background (see Exhibit 124.385a). Effective June 20, 1992, such parcels are mailable only as First-Class or Priority Mail.

* * * * *

Exhibit 124.385h. * * * * *

1. Generator (Mailer)

* * * * *

d. Description of contents of shipping container. Describe contents as "Used Medical Sharps." Do not use any other description.

* * * * *

124.385k Required Markings on Packages [Deleted]

* * * * *

124.388 Marking and Labeling

* * * * *

c. Before March 21, 1993, each exterior package containing used sharps must be marked with the words "Infectious Waste", or "Medical Waste"; or bear a label displaying the Universal Biohazard Symbol or the "International Biohazard Symbol" label. On and after March 21, 1993, the only part of this requirement remaining in effect will be that such packages must bear a label displaying the "International Biohazard Symbol" label. See 124.385a. No words describing the contents, nor any warning labels other than the "International Biohazard Symbol" label are to be placed on the exterior packages on or after March 21, 1993.

A transmittal letter making these changes in the Domestic Mail Manual will be published and transmitted automatically to subscribers. Notice of issuance of the transmittal letter will be published in the **Federal Register** as provided by 39 CFR 111.3.

Stanley F. Mires,

Chief Counsel, Legislative Division.

[FR Doc. 92–28338 Filed 11–23–92; 8:45 am]

BILLING CODE 7710–12–M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 60 and 61

[FRL–4537–3]

1992 Update for Delegation of Authority to the State of New Mexico for New Source Performance Standards (NSPS) and National Emission Standards for Hazardous Air Pollutants (NESHAP)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of Delegation of authority.

SUMMARY: The Environmental Protection Agency (EPA) announces the delegation of authority to the State of New Mexico to implement and enforce the New Source Performance Standards (NSPS) and National Emission Standards for Hazardous Air Pollutants (NESHAP). The provisions of full authority apply to all of the NSPS and NESHAP promulgated by the EPA through November 15, 1991, for NSPS and for NESHAP, and partial authority covers all new and amended standards promulgated after those dates, except as follows. The delegation of authority, under this notice, does not apply to: the sources located in Bernalillo County, New Mexico, the sources located on Indian lands as specified in the delegation agreement and in this notice, the standards of performance for new residential wood heaters (subpart AAA) under 40 CFR Part 60, and the NESHAP radionuclide standards specified under 40 CFR part 61.

EFFECTIVE DATE: November 3, 1992.

ADDRESSES: The New Mexico Environment Department's request and delegation agreement may be obtained by writing to one of the following addresses.

Mr. Thomas H. Diggs, Chief, Planning Section (6T-AP), Air Programs Branch, U.S. Environmental Protection Agency, 1445 Ross Avenue, suite 700, Dallas, Texas 75202, Telephone: (214) 655–7214.

Ms. Cecilia Williams, Chief, Air Quality Bureau, New Mexico Environment Department (NMED), Harold Runnels Building, room So. 2100, 1190 St. Francis Drive, Santa Fe, New Mexico 87503, Telephone: (505) 827–0042.

FOR FURTHER INFORMATION CONTACT: Mr. Ken Boyce, Planning Section, Air Programs Branch, U.S. Environmental Protection Agency, Region 6, 1445 Ross Avenue, suite 700, Dallas, Texas 75202, Telephone: (214) 655–7259.

SUPPLEMENTARY INFORMATION: Sections 111(c) and 112(l)(1) of the Clean Air Act allow the Administrator of the EPA to delegate EPA's authority to any State or local agency which can submit adequate regulatory procedures for implementation and enforcement of the NSPS and NESHAP programs. Authority for the NSPS and NESHAP programs were delegated to the State of New Mexico (except for sources located in Bernalillo County and Indian lands) on March 15, 1985.

On April 20, 1992, the State requested EPA to update the delegation of authority to the State for the NSPS and the NESHAP programs through November 15, 1991. The State's request

includes a revision of Air Quality Control Regulations 750 (NSPS) and 751 (NESHAP) as adopted by the New Mexico Environment Improvement Board. AQCRs 750 and 751 incorporate the Federal NSPS and NESHAP by reference through November 15, 1991.

The EPA reviewed the NMED request, Air Quality Control Regulations 750 and 751 and all other information submitted by the NMED, including its quest for implementation of the delegation of these programs. The EPA has determined that the State has adequate authority and effective procedures for implementing and enforcing the NSPS and NESHAP programs. Therefore, EPA is delegating full authority to the State through November 15, 1991, for NSPS and for NESHAP; and authority for the technical and administrative review of new or amended NSPS and NESHAP promulgated by the EPA after November 15, 1991, subject to conditions and limitations of the original delegation agreement dated March 15, 1985. It is important to note that no delegation authority is granted to the State for both Bernalillo County and Indian lands. Also, no authority is delegated to the State for 40 CFR part 60, subpart AAA, Standards of Performance for New Residential Wood Heaters, and for 40 CFR part 61 for the radionuclide NESHAPs. Specifically the subparts for which delegation is excluded are Subparts B (National Emission Standard for Radon—222 Emissions from Underground Uranium Mines), H (National Emission Standard for Radionuclide Emissions from Department of Energy Facilities), I (National Emission Standard for Radionuclide Emissions from Facilities Licensed by the NRC and Federal Facilities not covered by Subpart Phosphorus Plants), R (National Emission Standards for Radon Emissions from Phosphogypsum Stacks), T (National Emission Standards for Radon Emissions from the Disposal of Uranium Mill Tailings), and W (National Emission Standard for Radon—222 Emissions from Licensed Uranium Mill Tailings).

Today's notice informs the public that the EPA has delegated full authority to the State for implementation and enforcement of the NSPS and NESHAP promulgated by the EPA through November 15, 1991, and authority for technical and administrative review is delegated for the new and amended standards after that date. All of the required information, pursuant to the Federal NSPS and NESHAP (40 CFR part 60 and 40 CFR part 61) by sources located outside the boundaries of Bernalillo County and in areas outside of Indian lands, should be submitted directly to the New Mexico Environment Department, Harold Runnels Building, Room So. 2100, St. Francis Drive, Santa Fe, New Mexico 87503. Albuquerque/Bernalillo County is exempt due to this area being granted delegation authority under AQCRs 30 NSPS and 31 NESHAP to the City of Albuquerque's Environmental Health Department. Sources located on Indian lands in the State of New Mexico should submit required information to the EPA Region 6 office at the address given in this notice. All of the inquiries and requests concerning implementation and enforcement of the excluded standards under 40 CFR part 60, subpart AAA and 40 CFR part 61, subparts B, H, I, R, T and W, in the State of New Mexico should be directed to the EPA Region 6 Office.

The Office of Management and Budget has exempted this information notice from the requirements of Section 3 of Executive Order 12291.

This delegation is issued under the authority of section 111(c) and 112(l)(1) of the Clean Air Act, as amended (42 U.S.C. 7411(C) and 7412(D)).

List of Subjects

40 CFR Part 60

Air pollution control, Aluminum, sulfate plants, Cement industry, Coal, Copper, Electric power plants, Fossil-Fuel steam generators, Glass and glass products, Grain, Iron, Lead, Metals, Motor vehicles, Nitric acid plants, Paper and paper industry, Petroleum phosphate, Fertilizer, Sewage disposal, Steel, Sulfuric acid plants, Waste treatment and disposal zinc.

40 CFR Part 61

Air pollution control, Asbestos, Benzene, Beryllium, Hazardous materials, Mercury, Vinyl chloride.

Dated: November 3, 1992.

Joe D. Winkle,

Acting Regional Administrator.

[FR Doc. 92-28514 Filed 11-23-92; 8:45 am]

BILLING CODE 6560-50-M

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40 CFR Parts 261 and 271

[FRL-4536-5]

RIN 2050-AC32

Hazardous Waste Management System; Identification and Listing of Hazardous Waste; Toxicity Characteristic Revision

AGENCY: Environmental Protection Agency.

ACTION: Final rule.

SUMMARY: The Environmental Protection Agency (EPA or Agency) is amending its hazardous waste regulations under Subtitle C of the Resource Conservation and Recovery Act (RCRA) for testing conducted to evaluate a solid waste for the Toxicity Characteristic. Specifically, this rule removes the quality assurance (QA) requirement found in Method 1311, Toxicity Characteristic Leaching Procedure (TCLP), for correcting measured values for analytical bias (also referred to within this rule as spike recovery correction). However, this rule retains appropriate QA provisions, including that matrix spike recoveries be calculated and that the method of standard additions be employed as the quantitation method for metallic contaminants when appropriate as specified in the method.

EFFECTIVE DATE: November 24, 1992.

ADDRESSES: The official record for this rulemaking (Docket No. F-92-TCLC-FFFFF) is located at the U.S. Environmental Protection Agency, 401 M Street, SW, Washington, DC 20460 (room M-2427), and is available for viewing from 9 a.m. to 4 p.m., Monday through Friday, excluding Federal holidays. The public must make an appointment to review docket materials by calling (202) 260-9327. The public may copy a maximum of 100 pages of material from any one regulatory docket at no cost; additional copies cost $0.15 per page.

FOR FURTHER INFORMATION CONTACT: For general information, contact the RCRA Hotline at (800) 424-9346 (toll free) or call (703) 920-9810; or, for hearing impaired, call TDD (800) 553-7672 or (703) 486-3323. For information concerning the TCLP, contact Kim Kirkland, Office of Solid Waste (OS-331), U.S. Environmental Protection Agency, 401 M Street, SW., Washington DC 20460, (202) 260-4761.

SUPPLEMENTARY INFORMATION:

I. Authority

This amendment to the hazardous waste regulations in 40 CFR parts 261 and 271 is being promulgated under the authority of sections 1006, 2002, 3001, 3002, and 3006 of the Solid Waste Disposal Act of 1976, as amended by the Resource Conservation and Recovery Act of 1976, as amended [42 U.S.C. 6905, 6912(a), 6921, 6922, and 6926].

II. Background

On February 8, 1990 (55 FR 4440), the Agency published a notice of data availability that reopened the comment

period for a January 23, 1989 notice (54 FR 3212), which proposed to update SW–846 and to designate specific quality control procedures as mandatory for all testing conducted pursuant to subtitle C of RCRA, including the TCLP. The February, 1990 notice issued for comment a revised Chapter One of SW–846 entitled "Report on Minimum Criteria to Assure Data Quality" which included spike recovery correction as one of the QA requirements for RCRA subtitle C analyses. In that notice, the Agency stated that it believed that it was appropriate to correct a measured concentration for recovery and set out its intent to require that reported values be corrected for spike recovery. The purpose of this requirement was to provide more accurate data in those situations where there was a significant analytical bias in the data due to low recoveries of the analytes of interest.

On March 29, 1990, (55 FR 11796), EPA promulgated a rule to revise the then existing Toxicity Characteristic, which is used to identify those wastes that are hazardous and thus subject to regulation under subtitle C of RCRA. The rule broadened and refined the scope of the hazardous waste regulatory program and fulfilled specific statutory mandates under the Hazardous and Solid Waste Amendments (HSWA) of 1984. The regulatory language of the March 29, 1990 rule replaced the Extraction Procedure (EP) toxicity test with the Toxicity Characteristic Leaching Procedure (TCLP). The TCLP was promulgated in appendix II to 40 CFR part 261 and was designated as EPA Method 1311, to be incorporated in "Test Methods of Evaluating Solid Waste (Chemical/Physical Methods)", SW–846. The March 29, 1990, rule required that matrix spike recoveries be calculated and that the method of standard additions be employed as the quantitation method for metallic contaminants when appropriate as specified in the method.

On June 29, 1990 (55 FR 26986), the Agency promulgated a final rule which made technical corrections to the March 29, 1990 final rule, including the regulatory language in 40 CFR part 261, appendix II (Method 1311, the TCLP). These corrections reorganized the TCLP in 40 CFR part 261, appendix II, to correspond to the current version of SW–846. In addition, the quality assurance section of the TCLP was clarified by adding a requirement for the spike recovery correction. The spike recovery correction requirement was added to assure consistency with SW–846 Chapter One requirements which were proposed in the February 8, 1990 notice. Since the objectives to be achieved through the method of standard additions were being addressed through spike recovery correction, that method no longer was referenced separately in the QA provisions of the TCLP.

At the time that the TCLP was promulgated in its current form on June 29, 1990, the Agency expected to promulgate Chapter One of SW–846, as proposed on February 8, 1990, with the spike recovery correction requirement. The Agency expected that the promulgation of Chapter One would occur prior to the effective date of the TC final rule. However, the Agency has not yet promulgated a rule finalizing Chapter One, as proposed on February 8, 1990, but based upon comments received on that chapter, the Agency has reassessed its position respecting the matrix spike correction requirement.

III. Response to Comments Regarding Spike Recovery Correction and Basis for Amendment to 40 CFR Part 261, Appendix II

Many of the commenters to the February 8, 1990 notice indicated that the requirement for spike recovery correction should not be mandatory.[1] In particular, a number of commenters raised questions relative to the practical aspects of implementation of the requirement (e.g., how to add the spike, how many compounds must be spiked, how many samples must be spiked) as well as the burdensome nature of implementation for wastes with matrix interference problems. Wastes with matrix interferences often require dilution in an attempt to reduce or eliminate the interferences. As a result, detection limits could be elevated and one might not be able to determine if a compound of interest is present below the regulatory threshold. In addition, interferences may not equally affect the sample and the spike. Commenters also expressed concern about bias correction when applied to a constituent that is poorly recovered from a sample matrix. In the case of zero percent recovery, one may not be sure that the laboratory could have detected the presence of the analyte if it were present.

The Agency recognizes that spike recovery correction is a complex issue and now believes that there is a need for further evaluation and more detailed guidance on the specific implementation procedures. Therefore, in response to public comment received on the February 8, 1990, Federal Register notice, the Agency has decided not to proceed with the proposed spike recovery correction requirements in its subtitle C analytical procedures, and is withdrawing the requirement for bias correction of analytical spiked samples from the TCLP.

As a result, it is also necessary to amend Appendix II of 40 CFR part 261 and remove all text in the existing TCLP which imposes a requirement for correcting measured values for analytical bias. Specifically, in today's final rule, § 8.2 is revised whereby the following sentence is deleted: "The bias determined from the matrix spike determination shall be used to correct the measured values. (See §§ 8.2.4 and 8.2.5.)" In addition, § 8.2.5 is deleted, which provided a formula for spike recovery correction.

Today's rule withdraws the spike recovery correction requirement from the TCLP and, except for technical and format changes made in the June 29, 1990, rule revising the TCLP (55 FR 26986), returns the QA provisions of the TCLP to those promulgated on March 29, 1990 (55 FR 11796). As a result, matrix spike recoveries must be calculated (as set forth in revised § 8.2 of the TCLP) and the method of standard additions must be employed as the quantitation method for metallic contaminants when appropriate as specified in the method (as set forth in revised § 8.4 of the TCLP). In addition, the Agency has made a technical correction to the regulatory language in § 8.4 to specify the use of initial calibration quantitation methods for metallic contaminants. The Agency feels this technical correction is appropriate because, at present the method of standard additions is inapplicable to organic contaminants. Wastes identified as hazardous through TCLP testing utilizing matrix spike recovery correction must be managed as hazardous wastes, unless and until such wastes are reevaluated using recalculations of existing data or the TCLP test procedure as described in today's rule or otherwise reevaluated and found to be non-hazardous.

IV. State Authority

A. Applicability of Rule in Authorized States

Under section 3006 of RCRA, EPA may authorize qualified States to administer and enforce the RCRA program within the State. (See 40 CFR part 271 for the standards and requirements for authorization.) Following authorization, EPA retains enforcement authority under sections 3008, 7003 and 3013 of RCRA, although

[1] Other comments, together with the Agency's response thereto, have been placed in the official record for this rulemaking.

authorized States have primary enforcement responsibility.

Prior to the Hazardous and Solid Waste Amendments of 1984 (HSWA), a State with final authorization administered its hazardous waste program entirely in lieu of EPA administering the Federal program in that State. The Federal requirements no longer applied in the authorized State, and EPA could not issue permits for any facilities in the State that the State was authorized to permit. When new, more stringent Federal requirements were promulgated or enacted, the State was obliged to enact equivalent authority within specified time frames. New Federal requirements did not take effect in an authorized State until the State adopted the requirements as State law.

In contrast, under section 3006(g) of RCRA, 42 U.S.C. 6926(g), new requirements and prohibitions imposed by HSWA take effect in authorized States at the same time that they take effect in nonauthorized States. EPA is directed to carry out those requirements and prohibitions in authorized States, including the issuance of permits, until the State is granted authorization to do so. While States must still adopt HSWA-related provisions as State law to retain final authorization, HSWA requirements are implemented by EPA in authorized States in the interim.

Today's rule is being promulgated pursuant to RCRA section 3001(g), a provision added by HSWA, and amends the Toxicity Characteristic Leaching Procedure (TCLP) in appendix II of 40 CFR part 261. Therefore, the Agency is adding today's rule to Table 1 in 40 CFR 271.1(j), which identifies the Federal program requirements that are promulgated pursuant to HSWA and that take effect in all States, regardless of their authorization status. States may apply for either interim or final authorization for the HSWA provisions identified in Table 1, as discussed in the following section of this preamble.

B. Effect on State Authorizations

Pursuant to sections 3001(g) of RCRA, a provision added by HSWA, EPA is revising the TCLP (40 CFR part 261, appendix II). Thus, the revisions to the TCLP will take effect in unauthorized states (i.e., states not authorized to implement any portion of the RCRA program) and all States which have not been authorized for the Toxicity Characteristic (TC) on the effective date. Today's rule deletes the requirements imposed in the revised final TCLP method (see 55 FR 26986, June 29, 1990) for spike recovery correction of analytical data. The Toxicity Characteristic was promulgated pursuant to a HSWA provision and must be adopted by States that intend to retain final authorization. However, today's rule provides for a standard that is less restrictive than was imposed in the final TC as promulgated on June 29, 1990, for hazardous waste determinations based on spike recovery adjusted data. Although States must modify their programs to incorporate the Toxicity Characteristic, they no longer are required to include spike recovery correction in those modifications. Section 3009 of RCRA provides that States may impose requirements that are broader in scope or more stringent than those imposed under Federal regulation. For states that have received final authorization for programs requiring spike recovery correction as part of the TCLP, those states have the option of modifying their programs to delete this requirement.

V. Effective Date

HSWA amended section 3010 of RCRA to allow rules to become effective in less than six months when the regulated community does not need the six-month period to come into compliance. Section 553(d) of the Administrative Procedures Act requires publication of a substantive rule not less than 30 days before its effective date unless the rule relieves a restriction or for other good cause. This rule is effective November 24, 1992 because the regulated community does not need six months to come into compliance therewith, and it relieves a regulatory restriction. Those reasons also constitute good cause for not delaying the effective date of today's rule. This amendment removes the spike recovery correction requirement from the TCLP and thus provides greater flexibility to the regulated community in testing solid waste for the Toxicity Characteristic.

VI. Regulatory Analyses

A. Regulatory Impact Analysis

Under Executive Order 12291, EPA must determine whether a regulation is "major" and, therefore, subject to the requirement of a Regulatory Impact Analysis. This rule removes the spike recovery correction requirement found in the TCLP and thus, reduces the overall costs and economic impact of EPA's hazardous waste regulations and provides greater flexibility to the regulated community in testing and monitoring solid waste. There is no additional economic impact, therefore, due to today's rule. This rule is not a major regulation; thus, no Regulatory Impact Analysis is required.

B. Regulatory Flexibility Act

Pursuant to the Regulatory Flexibility Act (5 U.S.C. section 601–612, Public Law 96–354, September 19, 1980), whenever an agency publishes a General Notice of Rulemaking for any proposed or final rule, it must prepare and make available for public comment a regulatory flexibility analysis (RFA) that describes the impact of the rule on small entities (i.e., small businesses, small organizations, and small governmental jurisdictions). No regulatory flexibility analysis is required, however, if the head of the Agency certifies that the rule will not have a significant impact on a substantial number of small entities

This rule will not have an adverse economic impact on small entities since its effect will be to reduce the overall costs of EPA's hazardous waste regulations and provide greater flexibility to the regulated community, including small entities. Therefore, in accordance with 5 U.S.C. section 605(b), I hereby certify that this rule will not have a significant economic impact on a substantial number of small entities (as defined by the Regulatory Flexibility Act). Thus, the regulation does not require an RFA.

c. Paperwork Reduction Act

There are no additional reporting, notification, or recordkeeping provisions in this rule. Such provisions, were they included, would be submitted for approval to the Office of Management and Budget (OMB) under the Paperwork Reduction Act, 44 U.S.C. 3501 et seq.

List of Subjects

40 CFR Part 261

Hazardous waste, Recycling, Reporting and recordkeeping requirements.

40 CFR Part 271

Administrative practice and procedure, Confidential business information, Hazardous materials transportation, Hazardous waste, Indians-lands, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Water pollution control, Water supply.

Dated: November 13, 1992.

William K. Reilly,

Administrator.

For the reasons set out in the preamble, title 40 of the Code of Federal Regulations is amended as set forth below.

PART 261—IDENTIFICATION AND LISTING OF HAZARDOUS WASTE

1. The authority citation for part 261 continues to read as follows:

Authority: 42 U.S.C. 6905, 6912(a), 6921, 6922, and 6938.

2. Part 261, appendix II is amended by revising the test of § 8.0 preceding table I to read as follows:

Appendix II—Method 1311 Toxicity Characteristic Leaching Procedure (TCLP)

* * * * *

8.0 Quality Assurance

8.1 A minimum of one blank (using the same extraction fluid as used for the samples) must be analyzed for every 20 extractions that have been conducted in an extraction vessel.

8.2 A matrix spike shall be performed for each waste type (e.g., wastewater treatment sludge, contaminated soil, etc.) unless the result exceeds the regulatory level and the data are being used solely to demonstrate that the waste property exceeds the regulatory level. A minimum of one matrix spike must be analyzed for each analytical batch. As a minimum, follow the matrix spike addition guidance provided in each analytical method.

8.2.1 Matrix spikes are to be added after filtration of the TCLP extract and before preservation. Matrix spikes should not be added prior to TCLP extraction of the sample.

8.2.2 In most cases, matrix spikes should be added at a concentration equivalent to the corresponding regulatory level. If the analyte concentration is less than one half the regulatory level, the spike concentration may be as low as one half of the analyte concentration, but may not be less than five times the method detection limit. In order to avoid differences in matrix effects, the matrix spikes must be added to the same nominal volume of TCLP extract as that which was analyzed for the unspiked sample.

8.2.3 The purpose of the matrix spike is to monitor the performance of the analytical methods used, and to determine whether matrix interferences exist. Use of other internal calibration methods, modification of the analytical methods, or use of alternate analytical methods may be needed to accurately measure the analyte concentration of the TCLP extract when the recovery of the matrix spike is below the expected analytical method performance.

8.2.4 Matrix spike recoveries are calculated by the following formula:

$\%R$ (% Recovery) $= 100\,(X_s - X_u)/K$

where:

X_s = measured value for the spiked sample,

X_u = measured value for the unspiked sample, and

K = known value of the spike in the sample.

8.3 All quality control measures described in the appropriate analytical methods shall be followed.

8.4 The use of internal calibration quantitation methods shall be employed for a metallic contaminant if: (1) Recovery of the contaminant from the TCLP extract is not at least 50% and the concentration does not exceed the regulatory level, and (2) The concentration of the contaminant measured in the extract is within 20% of the appropriate regulatory level.

8.4.1 The method of standard additions shall be employed as the internal calibration quantitation method for each metallic contaminant.

8.4.2 The method of standard additions requires preparing calibration standards in the sample matrix rather than reagent water or blank solution. It requires taking four identical aliquots of the solution and adding known amounts of standard to three of these aliquots. The fourth aliquot is the unknown. Preferably, the first addition should be prepared so that the resulting concentration is approximately 50% of the expected concentration of the sample. The second and third additions should be prepared so that the concentrations are approximately 100% and 150% of the expected concentration of the sample. All four aliquots are maintained at the same final volume by adding reagent water or a blank solution, and may need dilution adjustment to maintain the signals in the linear range of the instrumental technique. All four aliquots are analyzed.

8.4.3 Prepare a plot, or subject data to linear regression, of instrumental signals or external-calibration-derived concentrations as the dependent variable (y-axis) versus concentrations of the additions of standard as the independent variable (x-axis). Solve for the intercept of the abscissa (the independent variable, x-axis) which is the concentration in the unknown.

84.4.4 Alternately, subtract the instrumental signal or external-calibration-derived concentration of the unknown (unspiked) sample from the instrumental signals or external-calibration-derived concentrations of the standard additions. Plot or subject data to linear regression of the corrected instrumental signals or external-calibration-derived concentrations as the dependent variable versus the independent variable. Derive concentrations for unknowns using the internal calibration curve as if it were an external calibration curve.

8.5 Samples must undergo TCLP extraction within the following time periods:

SAMPLE MAXIMUM HOLDING TIMES (DAYS)

	From: field collection to: TCLP extraction	From: TCLP extraction to: preparative extraction	From: preparative extraction to: determinative analysis	Total elapsed time
Volatiles	14	NA	14	28
Semi-volatiles	14	7	40	61
Mercury	28	NA	28	56
Metals, except mercury	180	NA	180	360

NA = Not applicable.

If sample holding times are exceeded, the values obtained will be considered minimal concentrations. Exceeding the holding time is not acceptable in establishing that a waste does not exceed the regulatory level. Exceeding the holding time will not invalidate characterization if the waste exceeds the regulatory level.

* * * * *

PART 271—REQUIREMENTS FOR AUTHORIZATION OF STATE HAZARDOUS WASTE PROGRAMS

3. The authority citation for part 271 continues to read as follows:

Authority: 42 U.S.C. 6905, 6912(a), and 6926.

4. In § 271.1, paragraph (j), Table 1 is amended by adding the following entry in chronological order by promulgation date:

§ 271.1 Purpose and scope.

* * * * *

(j) * * *

TABLE 1.—REGULATIONS IMPLEMENTING THE HAZARDOUS AND SOLID WASTE AMENDMENTS OF 1984

Promulgation date	Title of regulation	Federal Register reference	Effective date
*	*	*	*
November 24, 1992	Toxicity Characteristic Revision	57 FR 55117 publication citation	November 24, 1992.

[FR Doc. 92-28320 Filed 11-23-92; 8:45 am]

BILLING CODE 6560-50-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 433 and 447

[MB-062-IFC]

RIN 0938-AF42

Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule establishes in Medicaid regulations limitations on Federal financial participation (FFP) in State medical assistance expenditures when States receive funds from provider-related donations and revenues generated by certain health care-related taxes. The rule also adds provisions that establish limits on the aggregate amount of payments a State may make to disproportionate share hospitals for which FFP is available.

This interim final rule implements provisions of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991.

DATES: *Effective date:* These interim final rules are effective December 24, 1992. However, the statutory requirements at sections 2(c)(1) and 3(e)(1) of Public Law 102-234 have an effective date of January 1, 1992, and are effective on that date regardless of the effective date of this interim final rule. *COMMENT DATE:* Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 25, 1993.

ADDRESSES: Mail comments to the following address:

Health Care Financing Administration, Department of Health and Human Services, Attention: MB-062-IFC P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your written comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Due to staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code MB-062-IFC. Written comments received timely will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in room 309-G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202-690-7890).

Organizations and individuals desiring to submit comments on the reporting requirements discussed under the section on "Paperwork Burden" of this preamble should direct them to the Health Care Financing Administration at one of the addresses cited above, and to the Office of Information and Regulatory Affairs, Attention: Laura Oliven, Office of Management and Budget, New Executive Office Building (Room 3002), Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT:

Theresa Pratt (Donations and Taxes) (410) 966-9535

Betty Kern (Disproportionate Share Payments) (410) 966-4580

SUPPLEMENTARY INFORMATION:

I. Background

Title XIX of the Social Security Act (the Act) authorizes Federal grants to the States for Medicaid programs to provide medical assistance to persons with limited income and resources. Medicaid programs are administered by the States in accordance with Federal regulations. State Medicaid agencies conduct their programs according to a Medicaid State plan approved by the Health Care Financing Administration (HCFA). To carry out the mandates of the Medicaid program, the State agency pays providers for medical care and services provided to eligible Medicaid recipients. Providers that wish to participate in the Medicaid program must agree to comply with certain requirements specified in a provider agreement.

While Medicaid programs are administered by the States, they are jointly financed by the Federal and State governments. The Federal government pays its share of medical assistance expenditures to the State on a quarterly basis according to a formula described in sections 1903 and 1905(b) of the Act. The amount of the Federal share of medical assistance expenditures is called Federal financial participation (FFP). The State pays its share of medical assistance expenditures in accordance with section 1902(a)(2) of the Act.

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102-234), enacted December 12, 1991, amended section 1903 of the Act to specify limitations on the amount of FFP available for medical assistance expenditures in a fiscal year when States receive certain funds donated from providers and revenues generated by certain health care-related taxes. This law also amended section 1923 of the Act to establish limits on the amount of FFP for expenditures made to hospitals that serve a disproportionate number of Medicaid recipients and other low-income individuals. These hospitals are referred to as disproportionate share hospitals.

This interim final rule interprets and implements the provisions of Public Law 102-234. The two issues that are affected by this law (provider-related donations and health care-related taxes, and disproportionate share hospital payments) are addressed separately in this preamble.

II. Provider-Related Donations and Health Care-Related Taxes

Section 1902(a)(2) of the Act requires States to share in the cost of medical assistance expenditures, and permits both State and local governments to participate in the financing of the non-Federal portion of expenditures under the Medicaid program. This section specifies the minimum percentage of the State's share of the non-Federal costs, and requires that the State share be sufficient to assure that the lack of adequate funds from local government sources will not prevent the furnishing of services equal in amount, duration, scope, and quality throughout the State. Section 1903 of the Act requires the Secretary to pay each State an amount equal to the Federal medical assistance percentage of the total amount expended as medical assistance under the State's plan.

Public Law 102-234 amended section 1903 of the Act by adding a new subsection (w) regarding the receipt of provider-related donations and health care-related taxes by a State as the State's share of financial participation under Medicaid. In general, under section 1903(w) of the Act, a reduction in FFP will occur if a State receives donations made by, or on behalf of, health care providers unless the donations are bona fide donations or meet outstationed eligibility worker donation requirements, as specified in

the law. The law also specifies the types of health care-related taxes a State is permitted to receive without a reduction in FFP. Such taxes are broad-based taxes which apply in a uniform manner to all health care providers in a class, and which do not hold providers harmless for their tax costs. However, the law permits States which have received, by specific date prior to the enactment of this law, provider-related donations and health care-related taxes that are not permitted by this law, to continue to receive them during the State's transition period without a reduction in FFP.

Public Law 102–234 specifies that the Secretary may not restrict the use of funds derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the State share of Medicaid, unless the transferred funds are derived from donations or taxes that would not otherwise be recognized for Federal matching purposes. This provision applies regardless of whether the unit of government transferring the money is also a health care provider.

Funds transferred from another unit of State or local government which are not restricted by the statute are not considered a provider-related donation or health care-related tax. Consequently, until the Secretary adopts regulations changing the treatment of intergovernmental transfer, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).

Prior to the enactment of Public Law 102–234, regulations at 42 CFR 433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a State's share of financial participation in the entire Medicaid program. As mentioned previously, the statutory provisions of Public Law 102–234 do not include restrictions on the use of public funds as the State share of financial participation. Therefore, the provisions of § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations.

The provisions of Public Law 102–234 apply to all 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act. The exemption is currently limited to Arizona. The provisions apply to donations to State or local governments from providers and related entities and to revenues generated by health care-related taxes, regardless of whether these funds were directly or indirectly received by the Medicaid agency or some other department of the State or local government, and regardless of whether the State uses these funds as the State share of medical assistance expenditures for FFP purposes. However, the provisions do not apply to the treatment of donations from entities not related to providers or the receipt of revenues generated by generally applicable taxes or other non-health care-related taxes.

A discussion of the specific provisions of Public Law 102–234 relating to treatment of provider-related donations and health care-related tax revenues and the implementing regulatory provisions follows.

General Rule

Section 1903(w)(1) of the Act provides that, effective January 1, 1992, before calculating the amount of FFP, certain revenues received by a State will be deducted from the State's medical assistance expenditures. The revenues to be deducted are as follows:

Donations made by health providers and entities related to providers (except for bona fide donations and, subject to a limitation, donations made by providers for the direct costs of outstationed eligibility workers);

Impermissible health care-related taxes; and Until October 1, 1995, permissible health care-related taxes that exceed a specified limit.

It is important to note that the new statutory requirements apply to all impermissible provider-related donations and health care-related tax revenues received by State or local governments, without consideration of the use of the funds. If a State levies a tax on hospitals that is impermissible under section 1903(w) of the Act, and deposits the revenues in an account designated for some purpose other than Medicaid funding, the statute requires that the funds be offset from Medicaid expenditures even though the State is not using the revenues as its share of Medicaid expenditures for FFP purposes. For this purpose, the statute treats the State, and units of local government within the State, as a single entity. The fact that the funds were not received directly by the Medicaid agency does not alter the statute's requirements that the funds be reduced from the State's claimed expenditures.

Section 1903(w)(2)(A) of the Act defines "provider-related donations" as any donations or other voluntary payments (in-cash or in-kind) made directly or indirectly to a State or unit of a local government by a health care provider, an entity related to a health care provider, or an entity providing goods or services under the State plan and paid as administrative expenses. Section 1903(w)(2)(B) defines "bona fide provider-related donations" as provider-related donations that have no direct or indirect relationship (as determined by the Secretary) to payments made under title XIX to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established to the satisfaction of the Secretary. The statute also gives the Secretary the authority to specify, by regulation, types of provider-related donations that will be considered to be bona fide provider-related donations.

Section 1903(w)(3)(A) of the Act defines "health care-related taxes" as those taxes that are related to: (1) Health care items or services; (2) the provision of such items or services; (3) the authority to provide health care items or services; or (4) the payment for such items or services.

In accordance with section 1903(w) of the Act, we are defining the term "permissible health care-related taxes" to mean those health care-related taxes which are broad-based taxes, uniformly applied to a class of health care items, services or providers (as specified in section 1903(w)(7)(A) of the Act), and which do not hold a taxpayer harmless for the costs of the tax, or a tax program for which HCFA has granted a waiver. Health care-related taxes that do not meet these requirements are "impermissible health care-related taxes."

As specified in section 1903(w)(1)(C)(i) of the Act, these provisions apply to revenues received by a State on or after January 1, 1992 (except for certain donations and taxes permitted under a transition period, which are subject to a limit). Revenues received by States prior to January 1, 1992 are not subject to these statutory provisions. In addition, since these provisions restrict the receipt of taxes and donations, they do not apply to expenditures that are made on or after January 1, 1992, that are funded by these pre-January 1, 1992 revenues.

We are revising subpart B in 42 CFR part 433 to incorporate the statutory provisions of section 1903(w) of the Act

relating to States' receipt of provider-related donations and health care-related taxes. Under revised subpart B, we are adding §§ 433.50 through 433.74. Section 433.50, entitled Basis, scope, and applicability, includes a provision that this subpart apply to the 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act (section 1903(w)(7)(D) of the Act).

In § 433.52, General definitions, we are incorporating the statutory definitions of an entity related to a health care provider, provider-related donations and health care-related taxes. The statutory language provides the Secretary with the authority to specify when an entity or individual has a similar, close relationship to the provider for purposes of determining when an entity is related to a health care provider. Therefore, under the definition in this section, an entity related to a health care provider means (a) an organization, association, corporation, or partnership formed by or on behalf of a health care provider; (b) an individual with an ownership or control interest in the provider, as defined in section 1124(a)(3) of the Act; (c) an employee, spouse, parent, child, or sibling of the provider, or of a person with an ownership or control interest in the provider, as defined in section 1124(a)(3) of the Act; or, (d) a supplier of health care items or services or a supplier to providers of health care items or services. We have added this provision to make clear that businesses, i.e., laundry or meal services, who provide services to health care providers would be considered a related entity and subject to the provisions of this law.

Additionally, provider-related donations are defined under this section as a donation made directly or indirectly to a State or unit of local government by or on behalf of a health care provider, an entity related to a health care provider, or an entity providing goods or services to the State for administration of the State's Medicaid plan. Under this definition, donations made by a health care provider to an organization, which in turn donates money to the State, will be considered to be an indirect donation to the State by the health care provider. Thus, the statutory requirements pertaining to provider-related donations would apply.

We realize that many organizations receive nominal donations from providers and that States receive donations from many organizations. We have, therefore, determined that, if the organization receives less than 25 percent of its revenues from donations from individual providers and/or provider-related entities, the donation made to the State will be presumed to not be a provider-related donation and therefore is not affected by this interim final rule. However, if the donations from providers to an organization are subsequently determined to be indirect donations to the State or unit of local government for administration of the State's Medicaid program, then such donations will be considered to be provider-related. Therefore, the State may only receive these donations, without a reduction in FFP, if the statutory requirements pertaining to bona fide donations are met.

If the organization receives more than 25 percent of its revenues from donations from individual providers and/or provider-related entities, the organization will be considered as acting on behalf of health care providers or related entities. We specifically seek public comments on the percentage limit established for making this determination.

The amount of the organization's donations to the State during a State fiscal year that will be considered health care related will be based on the percentage of revenues the organization received from providers during that period. For example, if an organization received 30 percent of its revenues from providers, then 30 percent of the donation made by the organization to the State would be considered provider related. Therefore, the State may receive these donations, without a reduction in FFP, only if the statutory requirements pertaining to bona fide donations are met.

After consultation with State representatives, we want to emphasize that there is no limitation on donations from sources other than health care providers, related entities, or suppliers of administrative goods or services. Thus, States may continue to receive, without a reduction in FFP, contributions from charitable organizations that are not health care providers or acting on behalf of health care providers or related entities. Further, such donations may be permissible when made on behalf of health care providers or related entities when they satisfy the requirements of bona fide provider-related donations.

Section 433.53 contains requirements for State plans regarding State financial participation. In § 433.54, we define bona fide donations in accordance with section 1903(w)(2)(B) of the Act. A bona fide donation is a provider-related donation that has no direct or indirect relationship to Medicaid payments to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity as established by the State to the satisfaction of the Secretary. Provider-related donotions are determined to have no direct or indirect relationship to Medicaid payments if the donations are not returned to the individual provider, provider class, or related entity under a hold harmless provision or practice. A hold harmless practice exists if HCFA determines that any of the following applies: (1) The State or other unit of local government receiving the donation provides (directly or indirectly) for a payment (other than under title XIX) to the donating providers, and the amount of such payment is positively related either to the amount of the provider-related donation or to the difference between the amount of the donation and the amount of payment received under the State plan; (2) All or any portion of the payment made under title XIX to the donor, the provider class or any related entity varies only based upon the amount of the total donation received; or (3) The State or other unit of local government receiving the donation provides for any payment, offset, or waiver that guarantees to return any portion of the donation to the provider.

In defining the conditions under which a State or local government receiving a provider-related donation is determined to hold providers harmless for such donations, we have adopted the same statutory tests of hold harmless that apply to health care-related taxes. We believe that use of the same tests establish continuity and consistency in the treatment of funding sources addressed in this interim final rule. Moreover, although we considered developing a separate test for determining when States' payments are related to provider donations, we believe the tests designated in the law for determining when States' payments hold taxpayers harmless for their tax costs are equally useful for this purpose.

As mentioned above, section 1903(w)(2)(B) of the Act authorizes the Secretary to specify types of provider-related donations that will be considered to be bona fide provider-related donations. We believe this provision provides HCFA with the necessary discretion to determine the types of provider-related donations that will be considered bona fide. In making this determination, we have attempted to strike a meaningful balance between those donations that are presumably bona fide—assuming there is no hold

harmless effect—and those that cannot be presumed to be bona fide.

For a donation to be considered bona fide, the State must demonstrate, to HCFA's satisfaction, that it meets the requirements for bona fide donations specified in § 433.54. In considering the types of provider-related donations that would be presumed bona fide, we assessed the potential administrative burden to the States in requiring them to obtain "advance approval" from HCFA for each donation received. We believe an "advance approval" requirement for all provider donations could impose a significant burden on States.

To this end, we have determined that the types of provider-related donations that we will presume to be bona fide are those voluntary payments, including, but not limited to, gifts, contributions, presentations, or awards made by or on behalf of individual health care providers to the State, county, or any other unit of local government, that do not exceed $5,000 in any one year. In the case of a provider which is an organizational entity rather than a single individual, donations of $50,000 or less annually are presumed to be bona fide. However, if the donations are subsequently determined to have a direct or indirect relationship to Medicaid payments or a hold harmless provision or practice, they will no longer be considered to be bona fide.

We selected the levels of $5,000/$50,000 as the cutoff for presumption of donations as bona fide for several reasons. First, we wanted to establish a cutoff for this presumption at a sufficient level that ordinary charitable activity on the part of providers would be acceptable. We believe this activity would ordinarily not exceed the cutoff levels of $5,000/$50,000. Second, we wanted to minimize the administrative burden on the States and HCFA. Lower values would require more justification on the part of the States, and increased review activity by HCFA, on donations that are likely to meet the bona fide criterion. Third, we wanted to be able to detect and effectively control any potentially abusive situations. We believe that the levels in these interim final regulations meet these objectives. However, we invite comments from States, providers, and other interested parties on the specific cutoff figures specified in these regulations.

We want to make clear that at any time a State receives an inordinate number of individual or organizational donations that are at or under the monetary limits necessary for presumption of bona fide, HCFA may exercise its authority to perform an audit of such donations to determine if the provider-related donation is indeed bona fide.

When HCFA makes a determination that a donation presumed to be bona fide is not bona fide based on the criteria set forth, HCFA will deduct this amount from the State's medical assistance expenditures before calculating FFP. This decision and offset will apply to any similar donations previously received by the State and for all subsequent fiscal years in which a similar donation is received.

A donation from an individual provider or any health care organizational entity exceeding the monetary cap will require explicit authorization from HCFA prior to being considered bona fide. We want to make clear that, in the case of provider donations that are not presumed to be bona fide, States may seek HCFA approval at any time. HCFA will review the quarterly reports required by § 433.74. If, at the time the State submits its quarterly report to HCFA, it has not obtained authorization for the donations it received during that period, the authorization can be requested at that time. If HCFA determines provider-related donations are not bona fide, HCFA will deduct this amount from the State's medical assistance expenditures before calculating FFP for the year of receipt and for any subsequent fiscal year in which such a donation is received by the State.

After consultation with State representatives, we have determined that it will be the responsibility of the State to obtain the necessary certification of the fund source from the donating entity in establishing that a provider-related donation is bona fide.

A tax is considered a health care-related tax if it meets any of the three criteria specified in section 1903(w)(3)(A)(i) of the Act. Under these criteria, which are codified in § 433.55, a tax is considered to be health care related if—

- The tax is imposed on the provision of, or the authority to provide, health care services (e.g., a licensing fee);
- The tax is imposed on the payment for health care services (e.g., a tax on payments made by health insurance plans for the provision of health care items or services); or
- The tax is related to health care items or services. Under this criterion, a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers. For example, if a tax is imposed at equal rates on physicians and attorneys, and 85 percent of the burden falls on physicians, the tax is considered to be health care related.

One additional criterion imposed by section 1903(w)(3)(A)(ii) of the Act must be considered in determining whether a tax is health care related. Under this section, if the tax is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different than the tax treatment provided to other individuals or entities, the tax on health care items or services is considered to be health care related. For example, if a tax is imposed on physician and attorney services, but they are taxed at different rates, the tax on physician services is considered to be a separate health care-related tax on physician services.

Further, in determining if the treatment of a tax applicable to health care providers is different from the treatment of other taxpayers, HCFA will take into account any State credits or rebates to any of the payers. For example, if a tax is imposed at the same rate on physician and attorney services, but the attorneys receive tax credits for payment of this tax, this would be considered as taxation at different rates. Thus, the tax would be considered a health care-related tax, and would be subject to the provisions of the law relating to health care-related taxes.

If a State's tax program does not meet any of the above criteria, taxes imposed under the tax program are not health care-related taxes and, therefore, are not subject to the remaining statutory and regulatory provisions.

Section 433.55(e) specifies that health care insurance and HMO premiums are not payments for "health care items and services." We included this provision to make clear that, for purposes of defining the term "health care-related tax," we will not consider individual and group payments for such premiums as payments for health care items and services. Payments for health care insurance and HMO enrollment premiums are made to the insurer or HMO, for their use and to ensure coverage. Such payments may or may not be used to purchase or provide health care items or services for that individual or group.

It is important to note that any mandatory payment, fee, or assessment that is imposed by a State or local government unit, and which is related to health care items or services, providers of those items or services, or payments for health care services, is considered to be a health care-related tax and subject to the provisions of these regulations. Consequently, any health care-related taxes, regardless of their purpose, must meet several requirements in order to

avoid a reduction in FFP. These requirements are specified in § 433.68. This section requires that health care-related taxes are permissible only if they are broad-based, uniformly imposed, and do not hold taxpayers harmless for their tax costs. In order for a tax to be considered broad based, it must apply to all items and services within a class of items and services specified in section 1903(w)(7)(A) of the Act.

In § 433.56, we incorporate the classes of health care services and providers specified in section 1903(w)(7)(A) of the Act. After consultations with State representatives, we believe there is a general understanding that, since the class definition is determined by the type of service provided, only the revenues or activities of the provider pertaining to that class of service need be covered by the tax. Accordingly, a tax imposed on inpatient hospital services, or the providers thereof, need not cover revenues or activities of hospitals not related to inpatient hospital services, such as a separate wing certified as a nursing facility (NF) or a research laboratory.

For purposes of these interim final regulations, each of the following will be considered as a separate class of health care items or services. Taxes that pertain to each class must apply to all items and services within the class, regardless of whether the items or services are furnished by or through a Medicaid-certified or licensed provider.

- Inpatient hospital services.
- Outpatient hospital services.
- NF services (other than services of intermediate care facilities for the mentally retarded (ICF/MRs)).
- Intermediate care facility services for the mentally retarded, and similar services furnished by community-based residences for the mentally retarded, under a waiver under section 1915(c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/MRs prior to the grant of the waiver.
- Physicians' services.
- Home health care services.
- Outpatient prescription drugs.
- Services of health maintenance organizations (HMOs) and health insuring organizations (HIOs).

It is important to note that inpatient hospital services include all services defined as inpatient hospital services, such as inpatient psychiatric services. Additionally, based on our consultations with States representatives, we are adding the following additional class of items and services:

- Other health care items and services not listed above on which the State has enacted a licensing or certification fee.

The additional class that we have added includes any licensing or certification fee on medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. The State revenues from the fees collected must be established so that they do not exceed the State's cost of operating the licensing or certification program. If the fee exceeds the estimated projected cost of operating the licensure or certification program, the entire program will be barred from the class. Such fees, whether enacted prior to or subsequent to the enactment of Public Law 102-234, would be permissible to the extent they are broad based and uniform and do not hold taxpayers harmless for the cost of the fee. It should be noted, that if this class is not added, licensing or certification fees will be excluded because the law defines as impermissible any tax imposed on classes other than those designated classes of items and services. We believe that taking a disallowance with respect to broad-based and uniform licensing or certification fees on items or services not listed in the statute which do not hold taxpayers harmless would be inconsistent with the intent of the law.

It should also be noted that a licensing or certification fee on health care items and services not listed above which was in existence prior to the enactment of Public Law 102-234, and which does not meet the broad-based and uniform requirements of the law, will only be permissible during a State's transition period, unless the State requests, and HCFA approves, a waiver of these requirements, and the payers are not held harmless.

Section 1903(w)(7)(A)(iv) of the Act includes, within the list of health care items and services on which permissible taxes may be enacted, services of intermediate care facilities for the mentally retarded (ICF/MRs). In incorporating this class in the regulation, we have clarified this provision to include within that class of facilities certain group homes for the mentally retarded that provide services, under a waiver, similar to ICF/MR services. We added these homes because, in some States, many former ICF/MRs were converted to group homes under the waivers. These facilities could easily be converted back to ICF/MRs. Because of the ability of these facilities to be converted, and because of our desire to ensure that taxes are as broad-based as possible, we have added these group homes to the ICF/MR class.

In implementing the provision in the statute that permits expansion of the list of permissible classes, we could have chosen to provide a limited expansion of the list at this time. This decision would act as a strong control on the enactment of new tax programs. On the other hand, a second option was to provide an extensive expansion of the list, on the theory that such taxes would be permissible up to the limits prescribed in the statute, as long as they were broad based and uniform. In limiting the expansion to licensing fees for purposes of this interim final rule, we chose a middle ground approach to permit only ordinary fee programs designed to cover the costs of licensing providers and to clarify that States include as providers of ICF/MR services, certain group homes that provide these services under a waiver. This option was selected because of our desire to permit these ordinary State functions to occur, but not to encourage the development of new tax programs that could have adverse effects on Federal funding, particularly after October 1, 1995, when the cap on health care-related taxes expires.

However, we intend to remain flexible for purposes of the final rule in deciding whether and/or how to expand the list to include other legitimate classes. The statute constrains this flexibility by not providing any waiver authority regarding additional classes and by requiring that any additional classes of health care items and services must be established by regulation. We intend to review this issue carefully before publishing a final rule. Therefore, we request public comments on whether we should define additional specific classes of health care items and services. We also particularly request comments on which additional classes should be added to the list, and what criteria could be used by the Secretary in evaluating what classes should be added in the future. An example of criteria that could be considered for defining additional classes of items or services include State licensure and certification requirements and requirements that the tax apply to a sufficient mix of patients to ensure that the tax is generally redistributive.

It should be noted that there is nothing in the statute that precludes States from imposing a tax on more than one of the classes listed above. When a State imposes a tax on more than one class of items or services, the effect of the tax will be measured in the aggregate. This is particularly important

when determining if taxpayers are held harmless for the costs of the tax. The specific provisions relating to hold harmless are discussed later in this preamble.

Section 433.57 specifies the general rules regarding revenues from donations and taxes, in accordance with section 1903(w) of the Act. Under this section, effective January 1, 1992, HCFA will deduct from a State's expenditures for medical assistance, before calculating FFP, funds from provider-related donations and revenues generated by health care-related taxes received by a State or unit of local government, if the donations and taxes are not (1) Permissible provider-related donations, (2) permissible health care-related taxes, or (3) during a specified transition period, donations and taxes that meet certain requirements.

Rules Regarding Revenues From Donations and Taxes During a Transition Period

Section 1903(w)(1)(C)(ii) of the Act provides for a transition period during which, under certain circumstances, States may receive, without a reduction in FFP, revenues from provider-related donation programs and impermissible health care-related tax programs in effect prior to the enactment of Public Law 102–234. However, in order for the tax or donation program to be continued after the transition without a reduction in FFP, the law requires that the tax and donation programs meet specific requirements.

Specifically, section 1903(w)(1)(C)(ii) of the Act provides that donations received prior to the expiration of a State's transition period are eligible for Federal matching if the donations are received under a donation program that was in effect on September 30, 1991, described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, or substantiated by written documentary evidence, and if the program was applicable to State fiscal year 1992. States may demonstrate that their donations are applicable to State fiscal year 1992 through State plan amendments, written agreements, State budget documents, or other documentary evidence in existence on September 30, 1991.

Section 1903(w)(1)(C)(iii) of the Act provides that for States whose donation programs remain eligible for Federal matching funds in State fiscal year 1992, the total amount of donations in State fiscal year 1993 cannot exceed the total amount of donations received in the corresponding period plus 5 days after the end of the period of State fiscal year 1992.

Section 1903(w)(1)(D) of the Act provides that tax revenues received from impermissible taxes during a State's transition period are eligible for Federal matching funds if the tax was in effect as of November 22, 1991, or if the legislation or regulations imposing these taxes were enacted or adopted as of November 22, 1991.

Section 1903(w)(1)(E) of the Act provides that, when calculating the total amount of donations and taxes permitted during the transition period for the portion of State fiscal year 1992 that occurs in calendar year 1992, and for State fiscal year 1993, the total amount of impermissible donations and taxes permitted cannot exceed 25 percent of the non-Federal share of medical assistance expenditures minus the total amount of revenues from permissible broad-based health care-related taxes received in that year (or portion thereof). For States with a State base percentage greater than 25 percent, the total amount of impermissible donations and taxes permitted during the transition period cannot exceed the product of the State base percentage and the non-Federal share of Medicaid expenditures, minus the total amount of revenues from permissible broad-based health care-related taxes received in that year.

Section 1903(w)(1)(F) of the Act specifies the duration of the different transition periods for States. Under this provision, the transition period expires on October 1, 1992 for States with a fiscal year beginning on or before July 1. This applies to the majority of States. For States whose fiscal years begin after July 1, the transition period extends until January 1, 1993. In addition, regardless of when their fiscal year ends, States without a regulatory scheduled legislative session in 1992 or 1993, and States with a provider-specific tax enacted on November 4, 1991 are eligible to receive Federal matching funds for otherwise impermissible donations and tax programs before July 1, 1993, subject to the conditions described above.

To interpret how States are to implement the transition period provisions in Public Law 102–234, we are adding § 433.58, Revenues from provider-related donations and health care-related taxes during a State's transition period, and § 433.60, Limitations on level of FFP for State expenditures from provider-related donations and health care-related taxes during a transition period. Sections 433.58 (a) and (b) delineate the general rule concerning the transition period and specify each State's transition period as provided for in section 1903(w)(1)(F) of the Act. Section 433.58(d) describes the criteria that must be met in order for a donation to be permissible during the State's transition period. We have included bona fide donations and donations for outstationed eligibility workers in this section of the regulations to ensure that all donations that are permissible during a State's transition period are clearly identified. It is important to note that these provisions governing permissible donations received during the transition period are not solely transition period-related provisions, and are addressed again in § 433.66, which specifies the criteria for permissible provider-related donations after the transition period.

Under § 433.58(d), to be permissible for purposes of FFP, donations received during a State's transition period must be one of the following:

- Bona fide donations (as defined in § 433.54, General definitions).
- Donations made by a hospital, clinic, or similar entity (such as a Federally-qualified health center) for the direct costs of State or local agency personnel who are stationed at that facility to determine the eligibility (including eligibility redeterminations) of individuals for Medicaid and/or to provide outreach services to eligible (or potentially eligible) Medicaid individuals. We want to emphasize that outreach activities for potentially eligible Medicaid individuals include the costs associated with the initial receipt and processing of Medicaid applications, regardless of whether the State or local worker actually determined eligibility. Direct costs of outstationed eligibility workers refers to the costs of training, salaries, and fringe benefits associated with each outstationed worker and similar allocated costs of State or local agency support staff. Such direct costs include the prorated cost of pamphlets and materials distributed by the outstationed eligibility workers at these sites. For example, if a State purchased pamphlets and other materials to be distributed for outreach activities totalling $100,000 and outstationed eligibility workers at these sites used 15 percent of these materials, the "pro rata share" that the State would be permitted to record in computing the amount of permissible donations from providers would be $15,000. Costs such as State agency overhead costs and the cost of advertising campaigns, as well as the costs of provider space, are not allowable for this purpose. After

consulting with States, we want to make clear that since we do not consider extensive outreach campaigns, such as television and other mass media promotions, within the context of outstanding, we believe that donations that otherwise meet the statutory requirements for charitable contributions or bona fide provider donations could be used for this purpose.

• Other provider-related donations, if the following conditions are met:

+The donation program was in effect on September 30, 1991, described in State plan amendments or related documents submitted to HCFA by that date, or substantiated by written documentary evidence that was in existence as of that date; and

+The donation program is applicable to State fiscal year 1992.

In implementing these provisions, States must demonstrate that the above criteria are met through written documentary evidence, as specified in § 433.58k(e). Paragraph (e) specifies that HCFA will consider as acceptable documentation such items as:

• Reference to the donation program in a State plan amendment or related documents, including a satisfactory response, as determined by HCFA, to a HCFA request for additional information;

• State budget documents identifying the amounts States expected to receive in donations;

• Written agreements with the parties donating the funds; and/or

• Other written documentation that identify amounts that States planned to receive in donations from specified organizations during the period.

It is important to note that, to be acceptable, the written documentary evidence must have been in existence on September 30, 1991.

During the transition period, donations (other than bona fide donations and donations for outstationed eligibility workers) that may be received, without a reduction in FFP, by a State in fiscal year 1992 (subject to the limitation imposed during the transition period) are those that the State can document that it intended to receive during that period. Under § 433.58(f), for any portion of State fiscal year 1993 that occurs during the transition period, the State may receive, without a reduction in FFP, the amount of donations that it received in the corresponding period in State fiscal year 1992 (including the 5 days after the end of that period).

It is important to note that in no case may the amount of donations and health care-related taxes permitted during a State's transition period in State fiscal year 1993, exceed the product of 25 percent or, if higher, the State base percentage, and the entire State fiscal year non-Federal share of Medicaid expenditures (including certain administrative costs) less revenues received from broad based health care-related taxes. There is no limit on the amount of bona fide donations a State may receive without a reduction in FFP. Effective October 1, 1992, the amount of donations for outstationed eligibility workers that a State may receive without a reduction in FFP may not exceed 10 percent of a State's medical assistance costs (Federal and State), exclusive of the costs of family planning activities.

Section 433.58(g) provides that, subject to certain limitations, States may receive revenues from tax programs during the State's transition period, without a reduction in FFP, if:

• The health care-related taxes are broad-based and uniformly imposed, and the taxpayer will not be held harmless; or

• The health care-related taxes are imposed under:

+ A tax program that was in effect as of November 22, 1991; or

+ Legislation or regulations that were enacted or adopted as of November 22, 1991.

In addition, we have identified the following circumstances under which a State may modify health care-related tax programs in existence as of November 22, 1991, without a reduction in FFP: (1) If the modification only extends to a tax program that is scheduled to expire before the end of the State's transition period, or makes technical changes that do not alter the rate of the tax or the base of the tax (e.g., the providers on which the tax is imposed) and do not otherwise increase the proceeds of the tax; or (2) If the modification only decreases the rate of the tax, without altering the base of the tax. These provisions were included in the regulations as a result of questions from States concerning what types of modifications can be made to existing impermissible tax programs. As a result, during a State's transition period, only modifications to impermissible tax programs in existence on November 22, 1991, that meet one of the specific circumstances or provisions described above, will be permitted without a reduction in FFP.

Section 433.60, Limitations on level of FFP in State expenditures from provider-related donations and health care-related taxes during the transition period, specifies limits and formulas for calculating the maximum amount of provider-related donations and health care-related taxes that a State may receive without a reduction in FFP during a State fiscal year in the State's transition period, in accordance with section 1903(w)(1)(E) of the Act.

It is important to note that Pub. L. 102-234 applies to all donations from providers and related entities and to all health care-related taxes. The governing factor for the treatment of the tax or donation program (i.e., for determining applicability in State transition periods and the amount of the transition cap) is whether or not the provider-related donation program was in effect on September 30, 1991, or, if the tax program was enacted or adopted as of November 22, 1991. The duration or the purpose of the program is irrelevant. Consequently, all provider-related donations and health care-related taxes in existence as described above are used to calculate the limit. Under § 433.60, the maximum amount of provider-related donations and health care-related taxes that a State may receive, without a reduction in FFP, during a State fiscal year in the State's transition period is expressed as a percentage of the State's total Medicaid expenditures (including all of the State's Medicaid program administrative costs). Specifically, the State's total medical assistance expenditures for its fiscal year is multiplied by the greater of 25 percent or the State base percentage.

The specific percentage to be applied for a State in any fiscal year is the greater of 25 percent or the "State base percentage." The State base percentage is calculated by dividing the amount of all provider-related donations and health care-related taxes (whether or not they are permissible) estimated to be received in State fiscal year 1992 by the State's share of the total amount estimated to be expended under the State plan during such State fiscal year This percentage is multiplied by the total non-Federal share of Medicaid expenditures (including all of the administrative costs) in that fiscal year to determine the actual dollar limit.

The statute provides special rules for the calculation of the amount of health care-related taxes to be included in the numerator of the formula for taxes that were not in effect for the entire fiscal year, but were enacted as of November 22, 1991. In this case, the amount of revenues to be included would be estimated as if the tax (or increase) were in effect for the entire fiscal year. In accordance with the statute, a subsequent decrease in the tax would not be taken into consideration in calculating the numerator. The law

requires HCFA to estimate the State fiscal year 1992 non-Federal share of Medicaid expenditures based on the best available data.

During the transition period, the 25 percent limit (or if higher, the State base percentage) will limit the amount of revenues States may receive from provider-related donations and health care-related taxes, and will apply to the sum of revenues received by States from—

- Provider-related donations, other than bona fide donations and donations for outstationed eligibility workers; and
- Health care-related taxes, including permissible taxes-and impermissible taxes still eligible for use during the transition period.

Revenues received from these sources in excess of the 25 percent cap (or the State base percentage) will be deducted from Medicaid expenditures before FFP is calculated. For example, assume a State with a July 1, fiscal year received provider-related donations in State fiscal year 1992 and collected $250,000 in provider-related donations in the September 1991 quarter. The transition period for this State extends through September 30, 1992. Assume further that the State base percentage for this State is 30 percent and its estimated State fiscal year 1993 Medicaid expenditures is $6 million. The State's limit for State fiscal year 1993 would be determined by multiplying its State base percentage by the State's share of total medical assistance expenditures (including administrative costs) for State fiscal year 1993 (i.e., $6 million multiplied by 30 percent would yield a State fiscal year 1993 limit of $1,800,000).

Given these assumptions, the amount the State can receive in provider-related donations based on the State's estimated fiscal year 1993 medical assistance expenditures is $250,000 (the amount it collected in the preceding corresponding period plus 5 days). Since the amount of provider-related donations the State is permitted to receive in this example is less than the State's limit for total donations and taxes for the year, this State may collect the remaining amount, without a reduction in FFP, from permissible and qualifying impermissible health care-related taxes.

Conversely, if the $250,000 in provider-related donations represented an amount greater than 30 percent of the State's medical assistance expenditures estimated for the entire State fiscal year 1993, then the excess amount would be deducted from the State's medical assistance expenditures before determining the amount of FFP that would be available.

Rules Regarding Revenues From Donations and Taxes After a State's Transition Period

Beginning on the day after a State's transition period has ended, Public Law 102–234 denied FFP for most donations from health care-providers and limits Federal matching funds for health care-related taxes. To incorporate these statutory provisions, we are adding new §§ 433.66 through 433.70, which delineate the rules and limitations regarding revenues from provider-related donations and health care-related taxes.

Section 433.66 specifies permissible provider-related donations after the transition period. This section provides that, except for provisions relating to donations for outstationed eligibility workers (which are effective on October 1, 1992), beginning on the day after a State's transition period ends, a State may receive revenue from provider-related donations, without reduction in FFP, only in accordance with the requirements specified in that section. Section 433.66(b) provides that in order to be permissible, provider-related donations must meet one of the following requirements:

- The donations must be bona fide donations, as defined in § 433.54. Note that after a State's transition period ends, the amounts permitted as bona fide donations would not be subject to the 25 percent cap or, if higher, the State base percentage; or
- The donations must be made by a hospital, clinic, or similar entity (such as a Federally-qualified health center) for the direct costs of State or local agency personnel who are stationed at the facility to determine the eligibility (including eligibility redeterminations) of individuals for Medicaid and/or to provide outreach services to eligible (or potentially eligible) Medicaid individuals. Direct costs of outstationed eligibility workers refers to the costs of training, salaries, and fringe benefits associated with each outstationed eligibility worker and similar allocated costs of State or local agency support staff. Such direct costs include the prorated cost of pamphlets and materials distributed by the outstationed eligibility workers at these sites. Costs such as State agency overhead costs and the cost of advertising campaigns, as well as provider space, are not allowable for this purpose. Beginning October 1, 1992, these donations are subject to the 10 percent limit described in § 433.67(a)(2).

As mentioned earlier in the preamble, since we do not consider extensive outreach campaigns within the context of outstationing, donations that otherwise meet the statutory requirements for charitable contributions or bona fide provider donations could be used for this purpose. Section 433.67, Limitations on level of FFP for revenues from permissible provider-related donations, specifies limits applicable to such donations in accordance with section 1903(w)(1)(A) and (B) of the Act. As mentioned earlier in the preamble, during a State's transition period, bona fide donations and, prior to October 1, 1992, the amounts permitted as donations for outstationed eligibility workers are not subject to the 25 percent cap or, if higher, the State base percentage. Under § 433.67(a)(1), there is no limit on the amount of bona fide provider-related donations that a State may receive without a reduction in FFP, as long as the bona fide donations meet the requirements of § 433.66(b)(1).

In addition, § 433.67(a)(2) provides that, effective October 1, 1992, regardless of when a State's transition period ends, the maximum amount of donations for outstationed eligibility workers that a State may receive without a reduction in FFP may not exceed 10 percent of a State's medical assistance administrative costs (Federal and State), exclusive of the costs of family planning activities. The 10 percent limit for provider-related donations for outstationed eligibility workers is not included in the limit in effect through September 30, 1995, for health care-related taxes as described in § 433.70.

Section 433.67(b) specifies that HCFA will deduct from a State's medical assistance expenditures, before calculating FFP, any provider-related donations that do not meet the requirements of § 433.66(b)(1), and provider-related donations for outstationed eligibility workers in excess of the limits specified in § 433.66(a)(2).

Section 433.68, Rules regarding revenues from health care-related taxes after the transition period, provides, in general, that revenues from broad-based health care-related taxes that are applied uniformly to providers, and which do not hold providers harmless for the costs of the tax, may be received by States without a reduction in FFP, subject to the limits specified in § 433.70. Revenues from health care-related taxes not meeting these statutory requirements are deducted from medical assistance expenditures before FFP is calculated.

As mentioned earlier in this preamble, any licensing fee, assessment or other

mandatory payment which is related to health care items or services, or to the provision of, the authority to provide, or payment for the health care items or services, as defined in § 433.55, is considered to be a health care-related tax. The term "tax" does not include a criminal or civil fine or penalty, unless the fine or penalty was imposed instead of a tax.

Under § 433.68(c), in order for a health care-related tax to be considered to be broad-based, it must:

• Be imposed at least on all items or services in the class furnished by all non-Federal, non-public providers in the State, or all non-Federal, non-public providers in a class. If imposed by a unit of local government, the tax must extend to all items, services or providers (or to all within a class) in the area over which the unit of government has jurisdiction; and

• Be imposed uniformly throughout the jurisdiction.

In accordance with section 1903(w)(7)(A) of the Act, we define classes of health care items, services and providers, in § 433.56. After consulting with State representatives, we believe it is necessary to emphasize that, for purposes of determining if a tax on a class of health care-related items or services is broad based, a class includes all providers of a particular class of service located in a State or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction. A tax need not cover out-of-State providers who provide service to State residents, or any out-of-State business of an in-State provider of health care-related items or services.

Under § 433.68(d)(1), a tax is considered to be uniformly imposed if it meets any one of the following criteria:

• If the tax is a licensing fee or similar tax imposed on a class of health care items or services, or providers of those health care items or services, the tax must be the same amount for every item and service or for every provider providing those items or services within the class.

• If the tax is a licensing fee or similar tax imposed on a class of health care items or services, or providers of those items or services, on the basis of the number of beds in the provider, the amount of the tax must be the same for each bed of each provider in the class.

• If the tax is imposed on provider revenues or receipts with respect to a class of items or services or providers of those health care items or services, the tax must be imposed at a uniform rate for all items and services, and providers of those items or services in the class on all the gross revenues or receipts, or on net operating revenues. We have defined net operating revenue to mean gross charges of facilities, less any amounts deducted for bad debts, charity care, and payer discounts.

• The tax is imposed on items or services on a basis other than those listed above, e.g., an admission tax, and the State establishes to the satisfaction of the Secretary that the amount of the tax is the same for each provider of such items or services in the class.

Conversely, under § 433.68(d)(2), a tax is not considered to be imposed uniformly if it meets either one of the following two criteria:

• The tax provides for any credits, exclusions, or deductions, even if made to third parties such as patients, that result in the return to providers, directly or indirectly through third parties, of all or a portion of the tax paid, and it results, directly or indirectly, in a tax program—

+ In which the net impact of the tax and payments is not generally redistributive; and

+ In which the amount of the tax is directly correlated to payments under the Medicaid program.

• The tax holds providers harmless for the cost of the tax.

A tax will, however, still be considered to be uniform if it excludes Medicaid or Medicare revenues.

Section 433.68(d)(3) specifies that, if a tax does not meet the criteria in 433.68(d)(1), but the State establishes that the tax is imposed uniformly in accordance with the procedures for a waiver specified in § 433.72, the tax will be treated as a uniform tax.

Section 433.68(f) specifies that a provider will be considered to be held harmless under a tax program if any of the following conditions applies:

• The State (or other unit of government) imposing the tax provides directly or indirectly for a non-Medicaid payment to those providers or others paying the tax and the amount of the payment is positively correlated either to the amount of the tax or to the difference between the Medicaid payment and the total tax cost.

• All or any portion of the Medicaid payment to the taxpayer varies based only on the amount of the tax payment.

• The State (or other unit of local government) imposing the tax provides, directly or indirectly, for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

Section 433.70, Limitations on level of FFP for revenues from health care-related taxes after the transition period, specifies limits and formulas for calculating the maximum amount of health care-related taxes that a State may receive without a reduction in FFP during a State fiscal year after the State's transition period, in accordance with sections 1903(w)(1)(A)(iv) and 1903(w)(5) of the Act. Under § 433.70(a)(1), subsequent to the end of a State's transition period, and extending through September 30, 1995, the maximum amount of permissible health care-related taxes that a State may receive without a reduction in FFP during a State fiscal year (or portion thereof) is expressed as a percentage of the total State share of Medicaid Program expenditures in that fiscal year (including all of the State's medical assistance administrative costs). Specifically, the State's total medical assistance expenditures (reduced by the amount of impermissible provider-related donations and impermissible health care-related taxes) are multiplied by the greater of 25 percent or the State base percentage, as described in our regulations. As mentioned earlier in the preamble, the 10 percent limit for donations from providers for outstationed eligibility workers described in § 433.67(a)(2) is not included in the limit in effect through September 30, 1995, for health care-related taxes.

Section 433.70(a)(2) provides that, beginning October 1, 1995, there is no limitation on the amount of health care-related taxes that a State may receive without a reduction in FFP, as long as the taxes meet the requirements specified in these regulations.

Section 433.70(b) provides the formula for calculating the amount of FFP when a State receives health care-related taxes that do not meet the definition specified in § 433.68, and when a State receives health care-related taxes in excess of the limit described in § 433.70(a)(1).

Section 1903(w)(3)(E)(i) of the Act provides for a waiver of the broad-based and uniform requirements. In accordance with this section, we are adding a new § 433.72, Waiver provisions applicable to health care-related taxes. Under this section, a State may submit to HCFA a request for a waiver of the broad-based tax and/or the uniformity requirements specified in the regulations. A request for a waiver should be submitted subsequent to enactment of the State law implementing the tax. A waiver will be effective the first day in the quarter in which the request is received even if the additional information necessary to complete an evaluation of the waiver request is submitted subsequent to that

quarter. We have included a special provision whereby a State may apply for a waiver of a tax program that was in effect prior to October 1, 1992. Such waiver requests must be submitted to HCFA within 90 days after publication of these interim final rules. If a State submits a waiver request for a tax that was in effect prior to October 1, 1992, the waiver may be granted effective no earlier than January 1, 1992 or, if later, the date of enactment of the tax.

In order for HCFA to approve a waiver request, the State must demonstrate that its tax program meets all of the following requirements:

- The net impact of the tax and any payments made to the providers by the State under the Medicaid program is generally redistributive in nature.
- The amount of the tax is not directly correlated to medical assistance payments.
- The tax program meets the hold harmless provisions specified in this regulation.

The following example illustrates how the requirements relating to health care-related taxes contained in Pub. L. 102–234 would be applied.

Assume that a State imposes a tax of 5 percent on gross revenues of hospitals and gas stations. The tax generates $100 million in revenues during the State fiscal year, of which $90 million is paid by the hospitals and is deposited into the State General Fund.

The fact that this tax includes hospitals does not in and of itself subject it to the provisions of Pub. L. 102–234. Nor is the dedicated use of the tax revenue a consideration in determining the applicability of the statutory requirements. Rather, in determining whether or not the provisions of the law apply to this tax program, it must first be determined, in accordance with section 1903(w)(3)(A) of the Act, if the tax program is considered "health care-related."

The tax described in this example applies to both health care items and services and non-health care items and services. Therefore, we would determine if this tax is considered to be health care-related in accordance with section 1903(w)(3)(A)(ii) of the Act (i.e., a tax is considered to be health care-related if the treatment of the tax for health care items and services is different from the treatment of the non-health care entity). Since the tax in our example is a flat rate based on gross receipts, this tax would not be deemed health care-related based on section 1903(w)(3)(A)(ii) of the Act.

We then need to determine if this tax is health care-related in accordance with section 1903(w)(3)(A)(i) of the Act (i.e., if 85 percent of the burden of the tax falls on health care providers). Since 90 percent of the tax revenue in this example is generated from providers of health care services, the tax paid by the provider is considered to be a health care-related tax under section 1903(a)(w)(3)(A)(i) of the Act.

If, in this example, the hospitals paid $60 million in tax revenue and the gas stations paid $40 million, the tax would not be considered health care-related, and would not be subject to the remaining provisions of the law.

Once it is determined that a tax is health care-related, additional analysis of the tax program must be done to determine if States may receive this revenue, subject to the limitations previously described in this rule, without a reduction in FFP. The tax revenue would be deducted from Medicaid expenditures, before calculation of FFP, unless the tax met three independent criteria. The tax must be broad-based, applied uniformly, and must not hold taxpayers harmless for their tax costs.

In order for a health care-related tax to be considered to be broad-based in accordance with section 1903(w)(3)(B) of the Act, it must be imposed at least on all items or services in the class furnished by all non-Federal non-public providers in a class. If the tax is imposed by a unit of local government, the tax must extend to all items, services, or providers (or to all within a class) in the area over which the unit of government has jurisdiction.

In the example, since the tax extends to all hospital services, it would be considered broad based. Further, since the tax is imposed at a flat rate on gross revenue, it satisfies the requirement that it is imposed uniformly.

We wish to point out that in the example above, the tax would still be considered to be broad based if the State included only all non-Federal non-public providers in the class. Moreover, the tax would still be considered imposed uniformly if it excluded Medicare or Medicaid revenues. However, if the tax did not apply to all hospital services, and/or provided a credit, deduction, or exclusion, other than those mentioned in the preceding paragraph, the State may submit an application to the Secretary requesting that the tax be treated as broad-based and/or uniform. The criteria for determining whether a tax is "generally redistributive" even though it is not broad-based and/or uniform are included in § 433.68(e)(1) and (2) of the regulations.

To illustrate, assume that the tax in the example above was imposed only on hospitals which have more than 500,000 total patient days per year. If the State can demonstrate that the requirements defined in § 433.68(e)(1) are met, a wavier of the broad-based requirement as described in section 1903(w)(3)(B) the Act could be granted. Under the waiver, although the tax would not be paid by all hospitals, the revenue would not be offset from medical assistance expenditures before calculating FFP.

Assume differently that the tax was imposed on all health care items or services in a class, but the State granted a $2,000 tax credit for each 100 Medicaid patient days per year. If the State can demonstrate that the requirements in § 433.68(e)(2) are met, a waiver of the uniformity provisions in section 1903(w)(3)(C) of the Act could be granted. Under the waiver, although the tax law contains a tax credit for certain hospitals, the revenue would not be offset from Medical Assistance expenditures before calculating FFP.

It is important to note that the potential availability of waivers is limited to the broad-based and the uniformity criteria. The hold harmless requirement may not be waived under this provision.

Even if a tax is deemed under waiver authority to be a broad-based health care-related tax that is applied uniformly, it must also be determined if a hold harmless provision exists as described in section 1903(w)(4) of the Act. If, in any of the illustrations above, it were determined that a hold harmless provision as described in § 433.68(f) exists, the waiver would be denied and the tax revenue would be subtracted from the State's Medical assistance expenditures before calculating FFP.

We elected not to establish a separate appeals process for waiver disapprovals. If a State believes that a waiver disapproval results in a disallowance of claims for FFP issued in accordance with 42 CFR 430.42 (Disallowance of claims for FFP), the State may appeal the waiver disapproval when it appeals the disallowance. The appeals process will be handled by the Departmental Appeals Board (DAB) in the context of any disallowance that results from the denial of the waiver.

Generally Redistributive

Section 433.68(e) provides the criteria under which HCFA will determine whether a tax is not broad based or uniform is "generally redistributive". In interpreting this statutory requirement, which appears at section 1903(w)(3)(E)(ii) of the Act, we have attempted to balance our desire to give

States some degree of flexibility in designing tax programs with our need to preclude use of revenues derived from taxes imposed primarily on Medicaid providers and activities.

For purposes of these regulations, we have interpreted the term "redistributive", as used in the statute, to mean the tendency of a State's tax and payment program to derive revenues from taxes imposed on non-Medicaid services in a class of items or services (or providers of these services), and to use these revenues as the State's share of Medicaid payments. To the extent that a tax is imposed more heavily on providers with low Medicaid utilization than high Medicaid providers, the tax would be considered redistributive.

In order to apply the "generally redistributive" test to a tax program that is not broad based or uniform, § 433.68(e) provides States with two quantitative tests to measure the degree to which a tax is "redistributive", in reference to a tax that is broad based and uniform. The tests will be calculated by States and the results subject to verification by HCFA. The first test applies to those situations in which a tax is uniform, but not broad based. That is, the test would be used for a tax that does not apply to all services or providers of those services in a class, but all services or providers subject to the tax are taxed uniformly. This test would be used, for example, in the case of a tax on inpatient hospital revenue that exempted rural hospitals.

The test would be calculated by the State by comparing the proportion of the tax applicable to Medicaid as proposed by the State, to the proportion of the tax applicable to Medicaid if it were broad based. For example, in the case of a tax applied to inpatient hospital revenue, but which exempts rural hospitals, the State would calculate in proportion of the tax revenue applicable to Medicaid under the tax as imposed, and under the tax if all providers were subject to the tax. In this example, the proportion of the tax would equal the Medicaid share of the hospital revenues.

The regulatory provision at § 433.68(e) would require the State to calculate the proportion of the tax applicable to Medicaid under a broad-based tax (designated as P1), and the proportion applicable to Medicaid under the tax as imposed by the State (called P2). The test of how redistributive the tax is would be measured by dividing P1 by P2. Note that if P1/P2 equalled one, the new tax would be exactly as redistributive as the broad-based tax, i.e., the tax would have the same proportion of tax applicable to Medicaid. If the value of P1/P2 were greater than one, the non-broad-based tax would be more redistributive than the broad-based one, i.e., less of the tax burden would fall on Medicaid services. If the value of P1/P2 were less than one, the non-broad-based tax would be less redistributive than the broad-based one. A value of P1/P2 of 0.5 would represent a tax that doubled the proportion applicable to Medicaid.

Under § 433.68(e), when the State demonstrates to the Secretary's satisfaction that P1/P2 is greater than 1, the waiver request will be approved automatically. HCFA will review other waiver requests only if the State demonstrates to the Secretary's satisfaction that the proportion of the tax applicable to Medicaid in the broad-based tax (P1), when divided by the proportion of the tax applicable to Medicaid under the waiver (P2), is at least equal to 0.95 but is not greater than 1. HCFA will approve such waiver requests if the value of P1/P2 is at least equal to 0.95 but is not greater than 1, and the tax excludes or provides credits or deductions only to one or more of the following providers of items and services within the class to be taxed:

- Providers that furnish no services within the class is the State;
- Providers that do not charge for services within the class;
- Rural or sole community hospitals; or
- Physicians practicing primarily in medically underserved areas.

Our intention is to define rural and sole community hospitals in accordance with the definitions already established by the Medicare program. A sole community hospital is defined in 42 CFR 412.92(a). An urban area is defined in 42 CFR 412.62(f)(ii). Based on these definitions already established in our regulations, we are defining a rural hospital as any hospital located outside of an urban area. In addition, we are defining physicians in medically underserved areas in accordance with section 1302(7) of the Public Health Service Act.

The second test, although similar to the first, would apply in situations in which the State is requesting a waiver of the uniformity requirement, whether or not the tax is broad-based. Under this test, the State would calculate two linear regressions, one for the tax program for which waiver is requested, and one for the tax if it were applied uniformly and as a broad-based tax. (A linear regression is a statistical technique in which ordinary least squares are used to fit a straight line to paired data coordinates.)

Under the test specified in § 433.68(e), a State seeking waiver of the uniformity requirements must demonstrate that its tax program meets the generally redistributive test by the following procedure:

- For the tax program for which the State is seeking a waiver, the State must calculate a linear regression using as the dependent variable each provider's percentage proportion of the total statewide tax paid by all providers in a 12-month period and as each provider's independent variable, the "Medicaid Statistic". By the term "Medicaid Statistic, we mean the number of the provider's taxable units applicable to the Medicaid program. If, for example, the State imposed a tax based on charges, the amount of the provider's Medicaid charges in a 12-month period would be its Medicaid Statistic. If the tax were based on days, the number of the provider's Medicaid days in a 12-month period would be its Medicaid Statistic. For purposes of this test, it is not relevant that a tax program exempts Medicaid from the tax.
- The State must calculate a linear regression as above, but under the assumption that the tax is broad based and uniformly applied.
- The slope (i.e., the X coefficient) of the linear regression applicable to the hypothetical broad-based uniform tax (called B1) is divided by the slope of the linear regression applicable to the tax for which a waiver is sought (called B2).
- When the State demonstrates to the Secretary's satisfaction that B1/B2 is greater than 1, HCFA will automatically approve the waiver request.
- HCFA will review other waiver requests only if the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least equal to 0.95 but is not greater than 1. HCFA will approve such waiver requests if the value of the B1/B2 is at least equal to 0.95 but not greater than 1, and the tax excludes or provides credits or deductions only to one or more of the following providers of items and services within the class to be taxed:

+ Providers that furnish no services within the class in the State;
+ Providers that do not charge for services within the class;
+ Rural or sole community hospitals; or
+ Physicians practicing primarily in medically underserved areas.
+ Physicians in primarily medically underserved areas.

While we believe that the intent of the waiver provision is to provide States with some degree of discretion in their tax programs, we do not believe its

intent is to provide States with the ability to design programs in which the tax burden is shifted significantly to Medicaid providers or activities. We also believe States should have some additional flexibility in the case of rural or sole-community hospitals or physicians in health underserved areas because of their importance to recipient access to services.

We seek public comments on the tests, as well as the specific numerical values in the tests, specified in this interim final rule.

Hold Harmless

Section 1903(w)(4) of the Act specifies three conditions under which a State or local government is determined to hold taxpayers harmless for their tax costs. If any of these criteria is met, a tax program would be determined to have a hold harmless provision and the tax is impermissible. This section also provides that States are not, however, precluded from using a tax to reimburse health care providers for medical assistance expenditures, or precluded from relying on this reimbursement to justify or explain the tax.

Taken together, we have interpreted the hold harmless provisions to mean that while States may use revenue from otherwise permissible taxes to increase payment rates to the providers subject to the tax, States may not make Medicaid or other payments to providers that result in taxpayers being repaid dollar for dollar for their tax costs. If such payments were permitted, there would be no restraint on States' ability to use provider taxes as the source of the non-Federal snare of Medicaid payments.

The first criterion, included in the regulations at § 433.68(f)(1), would determine a hold harmless to exist when a State or local government directly or indirectly provides for any non-Medicaid payment to taxpayers and the amount of the payment is positively correlated either to the amount of the tax or to the difference between the amount of the tax and the amount of the Medicaid payment. Examples of the types of situations which might fall under the criteria are:

- A State imposes a tax on NF charges. The revenue from the tax is used for two purposes. Some of the funds are used by the State as the State share of Medicaid rate increases to facilities. The remaining portion of the tax receipts are given to private pay patients in the form of grants to compensate them for the tax added to their nursing home bills. If the tax is considered to be levied on the nursing home, the State is using non-Medicaid funds to compensate nursing homes, indirectly, for the cost of the tax imposed on private charges. If the tax is considered to be levied on the third party, the State is directly providing for a non-Medicaid payment to a private pay patient that is positively correlated to the amount of the tax.
- A State imposes a tax on hospital revenues. The State uses the tax revenues in two ways. First, it uses part of the funds as the State share of disproportionate share hospital payment adjustments. Second, it repays hospitals whose DSH payment adjustments were insufficient to cover their tax costs. In this case, since the State is directly repaying taxpayers for the difference between their tax costs and the enhanced Medicaid payments, a hold harmless situation would exist.

The second criterion, as specified in the statute, provides another general test for determining when hold harmless situations exist. This provision would deem a hold harmless situation to exist when all or any portion of a State's Medicaid payment to a taxpayer varies only based upon the total tax paid. While this provision does not preclude States from using revenues from permissible taxes imposed on classes of health care items and services to increase general payment rates for those services, the provisions would deem a hold harmless situation to exist when the rate increase to a provider is related only to the amount of the tax paid by the provider.

The third criterion in the statute provides that a hold harmless is determined to exist when the State or local government imposing the tax provides for any direct or indirect payment, offset or waiver that guarantees to hold taxpayers harmless for any portion of their tax costs. We have interpreted this provision to mean that use of any State payment, or offset or waiver or other taxes or mandatory payments that would have been paid by the taxpayer, in a way that is guaranteed to repay the taxpayer for all or part of the cost of health care-related taxes, is a hold harmless situation. The third statutory criterion would also consider as a hold harmless any sort of explicit guarantee, for example, in a State law authorizing a health care-related tax, that assures repayment of tax costs. For example, if a State imposes a health care-related tax, but provides a credit against property taxes equal to the tax imposed on providers not participating in Medicaid, a hold harmless situation would exist.

We are also concerned about the application of the hold harmless provisions in cases in which States impose taxes on classes of items and services (such as ICFs/MR) which are predominantly furnished to Medicaid recipients. In these cases, repayment of the Medicaid share could be tantamount to a guarantee of repayment of the entire tax cost and would result in a hold harmless situation. If HCFA did not address this situation, it would be possible for States to levy excessive amounts of taxes on ICFs/MR and other high Medicaid providers, and use Medicaid rates to repay them for their tax costs. We specifically seek public comments on both the thresholds and policy of this test. This specific hold harmless test will be effective December 24, 1992.

In applying the "guarantee" requirement to this situation, we have adopted a two-prong test for determining when hold harmless situations exist when States impose disproportionate health care-related taxes. However, if an explicit guarantee exists, the tax would be impermissible and the two-prong test will not apply. If an explicit guarantee does not exist, the two-prong test will apply.

Under the first prong of the test, if the health care-related tax is applied at a rate that is less than or equal to 6 percent of the revenue received by the taxpayer (which we consider to be the average level of taxes applied to other goods and services in the States), the tax would be presumed to be permissible under this test. If an explicit guarantee does not exist and if the tax is applied at a rate that is in excess of 6 percent of the revenue received by the taxpayer, we will apply the second prong of the test to determine if an inexplicit guarantee exists in violation of the hold harmless provision.

Under the second prong, a numerical test would deem a hold harmless situation to exist when Medicaid rates are used to repay (within a 12-month period) at least 75 percent of providers for at least 75 percent of their total tax cost. We have selected this level because we think it strikes a reasonable balance between our need to assure that States do not use Medicaid rates to repay providers for tax costs in a way not permitted under the statute, and our desire to permit States flexibility in the design of their tax and payment programs. It is our belief that this requirement will largely affect only those tax programs placed on ICFs/MR, but may not impact on every State. We would not expect the 75/75 criterion to affect taxes on classes of providers in which at least 25 percent of providers do not participate in Medicaid at any significant level. If, as of December 24,

1992, a State has enacted a tax in excess of 6 percent that does not meet these requirements, HCFA will not disallow funds received by the State resulting from the tax if the State modifies the tax to comply with this requirement by April 1, 1993. If by April 1, 1993, the tax is not modified, funds received by States on or after April 1, 1993, will be disallowed. HCFA has selected this date to permit States time to come into compliance with the requirement.

In implementing this provision, the test will be applied to all providers in the class (or classes) subject to the tax. The test will be determined by comparing Medicaid rates to providers before the imposition of the tax to the Medicaid payment rates paid to providers after the tax.

To illustrate how this test would be applied, a State, upon request from HCFA, would be required to supply the following information for each provider subject to the tax:

- The average Medicaid rate paid to the facility in the period prior to the imposition of the tax;
- The average Medicaid rate paid to the facility within twelve months of the imposition of the tax; and
- The number of rate units (i.e. days, discharges, charges) in the year prior to imposition of the tax.
- The payment for each provider to which the tax cost would be compared would be calculated by multiplying the difference in the rates (#2–#1) by the measure of utilization (#3).

This test would compare each provider's tax payment to its Medicaid rate increase over a 12-month period. By using prior year's utilization, the test would not be affected by increases in utilization subsequent to the tax. If a State's tax and payment program were determined to violate the numerical test, all of the revenue received by the State from the taxpayers would be disallowed. In applying the hold harmless provision to State tax programs, HCFA will not apply any numerical test before the effective date of these regulations. Offsets from FFP made under this test will only be made after the effective date of the regulations.

Reporting Requirements

Section 4 of Public Law 102–234 amended section 1903(d) of the Act to require that each State submit information related to provider-related donations received and health care-related taxes collected by the State or units of local government during the Federal fiscal year. In a new § 433.74, Reporting requirements, we are requiring that, beginning with the first quarter of Federal fiscal year 1993, each State must submit to HCFA quarterly summary information on the source and use of provider-related donations (including all bona fide and "presumed to be bona fide" donations) received and health care-related taxes collected. Each State must also provide any additional information requested by the Secretary related to any other donations made by, any taxes imposed on, health care providers. Each State must provide this information with its regular quarterly budget and expenditure reporting, in accordance with the forms and procedures established by HCFA in section 2600 of the State Medicaid Manual. States' reports must present a complete, accurate, and full disclosure of all of their donation and tax programs and expenditures. If a State fails to comply with these reporting requirements, future grant awards will be reduced by the amount of FFP HCFA estimates is attributable to the sums raised by tax and donation programs as to which the State has not reported properly, until such time as the State complies with the reporting requirements. Deferrals and/or disallowances of equivalent amounts may also be imposed with respect to quarters for which the State has failed to report properly. Unless otherwise prohibited by law, FFP for those expenditures will be released when the State complies with all reporting requirements.

Information on the source and use of provider-related donations received and health care-related taxes collected for State fiscal year 1992 was obtained in a request made on May 6, 1992, to the States for purposes of calculating applicable State transition period limits. Instead of continuing this type of reporting process, we have incorporated this reporting into the States' normal budget and expenditure reporting processes and cycles. If, subsequent to a State's initial report, a State determines that it inadvertently omitted estimates for either donation programs applicable to State fiscal year 1992 (for which documentation existed showing the program was in effect as of September 30, 1991) or for tax programs enacted as of November 22, 1991, a State must submit this information to HCFA within 90 days after publication of these interim final rules. HCFA will then analyze this data and recalculate the applicable State's transition period limit.

While we are requiring States to only report summary information on a quarterly basis, States must maintain, in readily reviewable form, supporting documentation that provides a detailed description and legal basis for each donation and tax program being reported, along with the source and use of all donations received and taxes collected. This information must be made available to Federal reviewers upon request.

Consultation With States

Section 5(c) of Public Law 102–234 required HCFA to consult with the States before issuing regulations to implement the legislation. We have met this requirement by conducting a series of meeting with representatives of the National Governors Association, the National Council of State Legislatures, the National Association of Counties, the National Association of State Budget Officers, and the American Public Welfare Association. During these meetings, HCFA received written and oral input from these groups concerning the issues involved in developing these rules. To the extent possible, their views and ideas have been accommodated in the rules.

We also met with representatives of hospital organizations, including the American Hospital Association, the American Public Hospital Association, and the National Association of Children's Hospitals and related institutions, concerning the issues involved in implementing the statute. Again, to the extent possible, their views and ideas have been accommodated in the rules. These organizations were helpful in providing the perspective of hospitals concerning the donations and taxes and DSH payment requirements.

III. Disproportionate Share Hospitals

General Rule

Among the hospitals that agree to provide services to Medicaid recipients are certain hospitals that, because of their geographic location or various other reasons, serve a larger number of Medicaid recipients and other low-income individuals than other hospitals. These hospitals are referred to as disproportionate share hospitals (DSHs). Because DSHs provide services to a large population of Medicaid recipients and other low-income individuals, they are faced with special financial needs.

Section 1902(a)(13)(A) of the Act requires States to assure that their Medicaid payment rates take into account the situation of hospitals serving a disproportionate number of low-income patients with special needs.

Section 1923 of the Act contains a Federal definition of DSHs, delineates specific requirements that DSHs must meet to receive payment adjustments,

and specifies formulas for States to use to make payment adjustments to DSHs. Under section 1923 of the Act, States are free to establish their own criteria for determining whether a hospital qualifies as a DSH, subject to certain statutorily imposed minimums specified in section 1923(b) of the Act. In accordance with section 1923(c) of the Act, States are also free to choose one of three payment formulas to calculate the amount of the payment adjustment each DSH receives.

Prior to the enactment of Public Law 102–234, DSH payment adjustments were not subject to Federal limitations. Section 1902(h), in part, prohibited the Secretary from imposing an upper payment limit for DSHs. As a result, DSH payments have substantially increased. Therefore, the Congress found it necessary to impose limits on these payments.

Section 3 of Public Law 102–234 established limits on the amount of Federal financial participation (FFP) available for expenditures made to DSHs. Prior to enactment of this legislation, there were no imposed legal limits on Medicaid DSH payments. The provisions of section 3 of Public Law 102–234 affecting DSH payments apply to all 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act.

Specifically, section 3(a) of Public Law 102–234 deleted the prohibition on an upper payment limit for DSHs from section 1902(h) of the Act. Section 3(b) of Public Law 102–234 added subsection (f) to section 1923 of the Act which imposes two restrictions on DSH payments. One restriction is applicable from January 1, 1992 through September 30, 1991. A second restriction goes into effect on October 1, 1992.

The first DSH restriction, effective from January 1, 1992 through September 30, 1992, places a moratorium on DSH plans. Section 1923(f)(1) of the Act provides that States may receive FFP for DSH payments during the moratorium period only if the payments were made in accordance with one of the following:

A State plan in effect by September 30, 1991.

A State plan amendment submitted to HCFA by September 30, 1991.

A State plan amendment or modification submitted to HCFA between October 1, 1991 and November 26, 1991, if the amendment or modification was intended to limit the State's definition of DSHs to those hospitals with Medicaid inpatient utilization rates or low-income utilization rates (as defined in section 1923(b) of the Act) at or above the statewide arithmetic mean. A DSH payment methodology established and in effect as of September 30, 1991, or in accordance with State law enacted or State regulations adopted as of September 30, 1991.

A State plan amendment that increases DSH payments to comply with the minimum payment requirement described in section 1923(c)(1) of the Act, which provides for a payment adjustment based on the formula used in the Medicare program.

The second DSH restriction, effective October 1, 1992, establishes both national and State limits on DSH payments. The national limit is established at 12 percent of the total amount of medical assistance expenditures paid under Medicaid State plans during the Federal fiscal year. For the calculation of this limit, State administrative costs, by law, are excluded from medical assistance expenditures for this purpose.

In general, the State limit is similarly set at 12 percent of a State's medical assistance expenditures (excluding administrative costs). However, each State's DSH limit is based on the fiscal year 1992 DSH expenditures. Section 1923(f)(4)(C) of the Act defines a State base allotment as the total amount of DSH payment adjustments eligible for Federal matching during Federal fiscal year 1992 or $1 million, whichever is greater. States with DSH payments during Federal fiscal year 1992 above the 12 percent limit are defined in section 1923(f)(4)(A) of the Act as "high-DSH States." In accordance with section 1923(f)(2)(B) of the Act, States that are designated as "high-DSH States" will have DSH payment adjustments limited to the State base allotment.

States with aggregate DSH payments below the 12 percent limit are referred to as "low-DSH States." Section 1923(f)(2)(A) of the Act provides that these States are permitted to increase DSH payments to the extent their Medicaid programs grow, and to the extent that the sum of all States' DSH limits do not exceed the national 12 percent limit. The preliminary national DSH limit and the preliminary State-specific DSH limits are calculated prospectively, before the beginning of the Federal fiscal year (i.e., October 1). These preliminary limit calculations will be updated and published in the Federal Register by April 1 of each year and subsequently reconciled to actual expenditures by April 1 of the following year. The preliminary Federal fiscal year 1993 limits will be updated and published by April 1, 1993, and the final Federal fiscal year 1993 limits will be published April 1, 1994.

In calculating both the preliminary and final limits, DSH expenditures will be capped at 12 percent in accordance with the statutory requirements. If, in any year, DSH expenditures exceed 12 percent, HCFA will proportionally reduce the State DSH allotments for all States (that is, both high-DSH and low-DSH States) to ensure that the cap does not exceed the 12 percent statutory limit.

Section 3(b)(1) of Public Law 102–234 added a provision in section 1923(f)(1)(C) of the Act that requires the Secretary, before the beginning of each Federal fiscal year (beginning with fiscal year 1993), to estimate and publish in the Federal Register the national DSH payment limit and each State's allotment within that DSH limit.

Section 3(c) of Public Law 102–234 amended section 1923(b) of the Act by adding a new paragraph (4) which prohibits HCFA from restricting a State's authority to designate hospitals as DSHs. In light of this restriction, section 3(e)(2) of Public Law 102–234 provided that the proposed regulations that the Department had issued on October 31, 1991 (56 FR 56141) relating to the standards for defining DSHs under the Medicaid program be withdrawn and cancelled. This proposed rule would have prohibited States from defining as DSHs any hospital whose Medicaid or low-income utilization was below the statewide arithmetic mean. In accordance with section 3(e)(2) of Public Law 102–234, the Department published in the Federal Register on December 9, 1991 (56 FR 64228) a notice withdrawing the October 31, 1991 proposed rule.

Provisions of the Interim Final Rule

To interpret the statutory provisions of Public Law 102–234 regarding DSH payment limits, we are adding a new subpart E to part 447 entitled "Payment Adjustments for Hospitals that Serve a Disproportionate Share of Low-Income Patients." Under the new subpart E, we are adding a new § 447.296, Limitation on aggregate payments for disproportionate share hospitals for the period January 1, 1992 through September 30, 1992. This section provides the applicable limits on DSH payments for the moratorium period in effect January 1, 1992 through September 30, 1992. In addition, this section describes the specific criteria that determines the availability of FFP for DSH payments during this period. Under § 447.296, FFP is available for DSH payments made during the period January 1, 1992 through September 30, 1992, only if the payments are made in accordance with sections 1902(a)(13(A) and 1923 of the Act and are based on one of the following:

- A State plan in effect by September 30, 1991.

- A State plan amendment submitted to HCFA by September 30, 1991.
- A State plan amendment or modification submitted to HCFA between October 1, 1991 and November 26, 1991, if the amendment or modification was intended to limit the State's definition of DSHs to those hospitals with Medicaid inpatient utilization rates or low-income utilization rates (as defined in section 1923(b) of the Act) at or above the statewide arithmetic mean.
- A DSH payment methodology established and in effect as of September 30, 1991, or in accordance with State law enacted or State regulations adopted as of September 30, 1991.
- A State plan amendment submitted during the moratorium period (January 1, 1992 through September 30, 1992) that increases aggregate DSH payments to the minimum payment adjustment specified in section 1923(c)(1) of the Act. For this purpose, we are defining "minimum payment adjustments" as the aggregate payment adjustments required under section 1923(c)(1) of the Act for those hospitals that meet the Federal DSH definition, as described in section 1923(b) of the Act. In order to calculate this minimum payment amount, States will need to determine the payment adjustment that the Medicare methodology described in section 1923(c)(1) of the Act would yield for each hospital that qualifies as a DSH, in accordance with the Federal DSH definition described in section 1923(b) of the Act. The sum total of these hospital-specific calculations is the aggregate minimum payment amount adjustment under section 1923(c)(1) of the Act.

In order for a State to be able to amend its State plan during the moratorium period to meet the minimum payment requirements of section 1923(c)(1) of the Act, the State will need to demonstrate that its aggregate disproportionate share payments are below the aggregate minimum payment amount calculated for federally-qualified DSHs, as described above. We believe that this interpretation of the minimum payment requirements is in keeping with the Congressional intent of Public Law 102-234 to limit DSH payments.

It is important to note that this definition of the required minimum payment amount is merely a payment adjustment limitation that is to be used in measuring the amount of payment increases that can be allowed during the moratorium period. This provision does not limit States' flexibility in designating hospitals as DSHs. Rather, it establishes criteria for approvability of State plan amendments during the moratorium period.

After consultation with States, we have identified the following additional circumstances under which a State DSH plan amendment can be approved during the moratorium period:

A State plan amendment that provides for redistribution of DSH payments may be approved if the State documents to HCFA's satisfaction that its DSH payments under the State plan, as amended, pays no more in the aggregate than the amount that would have been paid to DSHs prior to the redistribution plan amendment and does not result in additional Federal expenditures.

- A State plan amendment that provides for reductions in DSH payments.

Based on these State consultations, questions raised by States, and State plan amendments submitted to HCFA concerning redistribution and reduction of payment issues, we are permitting States to amend State plans during the moratorium period that involve the above two circumstances. Although the above two circumstances were not specifically provided for in the statute, we believe the policy described above of permitting redistributions and reductions of DSH payments during the moratorium period does not violate Public Law 102-234. It is our belief that this policy is in keeping with the Congress' intent in passing Public Law 102-234. We believe this policy maintains State flexibility in determining DSH payments while limiting aggregate DSH payments to comply with the new DSH limits established by section 1923(f) of the Act.

Only State plan amendments that satisfy one of the specific criteria described above maybe approved during the moratorium period of January 1, 1992 through September 30, 1992. However, we believe it is important to point out that States may revise DSH amendments permitted under this section as may be necessary, subject to the above limitations, to respond to a HCFA request for additional information.

We have added a new § 447.297, Limitations on aggregate payments for disproportionate share hospitals beginning October 1, 1992, in which we specify the national and State DSH payment limits, beginning October 1, 1992. The provisions in this section apply to the 50 States and the District of Columbia. However, the provisions do not apply to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act. At the present time, this exception is limited to Arizona.

In § 447.297(b), we specify the national payment limit on aggregate DSH payments for any Federal fiscal year beginning on or after October 1, 1992. The preliminary national cap for DSH payments in any Federal fiscal year beginning on or after October 1, 1992 is equal to 12 percent of total medical assistance expenditures (excluding administrative costs) that are projected to be made during the Federal fiscal year under State plans. Projections will be made by HCFA prior to October 1 of each year. As explained later in this preamble, the projection of the national medical assistance expenditures will be updated and published in the **Federal Register** by April 1 during each year to which the projection applied and reconciled to actual expenditures by April 1 of the following year. For example, the preliminary Federal fiscal year 1993 limit will be updated and published in the **Federal Register** by April 1, 1993. The final Federal fiscal year 1993 national limit will be determined based on Federal fiscal year 1992 expenditure data reviewed and adjusted by HCFA through December 31, 1993. The final Federal fiscal year 1993 limit will be published in the **Federal Register** by April 1, 1994.

In addition to the national limit, there is a specific State limit for each State. The State limit is a specified amount of DSH payments above which FFP will not be available. This limit is called the "State DSH Allotment" and is described in new § 447.297(c). In accordance with this section, the DSH allotment for any State is limited to 12 percent of the State's total medical assistance expenditures (excluding administrative expenditures), unless the State is classified as a "high-DSH State." As discussed previously in this preamble, a high-DSH State is a State whose State base allotment exceeds the 12 percent limit. High-DSH States will have their State DSH allotment based on the aggregate dollar amount of DSH payments made in Federal fiscal year 1992. A preliminary DSH allotment for each State will be published by October 1 of each Federal fiscal year.

After consulting with States, we have added a process in § 447.297(d) of our regulations to revise the preliminary DSH allotment. Under this process, HCFA will revise the preliminary projections at two points in the Federal fiscal year. HCFA will calculate an update to its preliminary projections based on February Medicaid budget submissions, are reviewed and adjusted by HCFA if necessary. By April 1, HCFA will publish the updated preliminary

national limits and preliminary State DSH allotments in the Federal Register. This update allows States to make any mid-year adjustments they deem necessary to their DSH expenditure patterns so that they will not significantly be over or under their final DSH allotment.

Based on the information available as of the following December 31, HCFA will calculate the final DSH national 12 percent expenditure limit and the final individual State DSH allotments. These amounts will be published in the Federal Register by the following April 1. For example, the final Federal fiscal year 1993 national limit and State DSH allotments will be determined based on Federal fiscal year 1992 adjusted expenditure data submitted through December 31, 1993. The final Federal fiscal year 1993 national limits and State allotments will be published in the Federal Register by April 1, 1994. We will reconcile final State DSH allotments with actual State DSH expenditures. Those allotments DSH expenditures that are in excess of the final State DSH will be disallowed. No adjustment will be made to State DSH allotments that exceed actual DSH payments.

For purposes of establishing updated national and State limits for Federal fiscal year 1993 to be published in the Federal Register by April 1, 1993, HCFA will use actual and projected DSH expenditures as reported, reviewed, and adjusted, if necessary, by HCFA, based on the February 1993 Medicaid budget submission. Based on these data, HCFA will recalculate the national DSH limit, State allotments, and permissible State growth. For example, if the preliminary limits were calculated based on DSH expenditures for Federal fiscal year 1992 of $1.5 million, and the updated expenditures report submitted during February 1993 shows Federal fiscal year 1992 DSH expenditures of $2 million, the April 1 update calculations will be based on the $2 million of DSH expenditures. Also, these April 1, 1993 updated Federal fiscal year 1992 calculations will refine the preliminary national DSH expenditure cap and permissible State growth.

For Federal fiscal year 1994 and beyond, these April 1 updated limits will only refine permissible State growth and the national expenditure cap. Additionally, DSH payment increase made by States to meet the requirements of section 1923(c)(1) of the Act will be included. For example, if the preliminary Federal fiscal year 1994 limits calculated permissible State growth to be 5 percent, and the updated expenditure reports submitted during February determine the permissible State growth to be 5.5 percent, the April 1 updated calculations will be based on the 5.5 percent. Also, the April 1 updated calculations will refine the national expenditure cap to reflect State aggregate medical assistance expenditures, excluding administrative costs.

For Federal fiscal years 1994 and beyond, a State's DSH allotment is not affected (either increased or decreased) by actual DSH expenditures for that year. That is, after Federal fiscal year 1993, a State's DSH allotment will always be the prior year's DSH allotment increased by a State growth amount and, if available, the supplemental amount.

In accordance with section 1923(f)(1)(C) of the Act, we are specifying in new § 447.297(e) that, prior to the beginning of each Federal fiscal year, HCFA will estimate and publish in the Federal Register a projection of the national DSH payment limit and each State's DSH allotment for that year. This publication will begin with Federal fiscal year 1993 and will be published before October 1, 1992. By April 1 of the following Federal fiscal year, the final national DSH limit and State DSH allotments for the current fiscal year will be published in the Federal Register.

States will be required to submit an assurance in accordance with § 447.297(c) indicating they will not exceed their State DSH allotment. States can amend their State plans to make mid-year adjustments they deem necessary to their Federal fiscal year 1993 DSH expenditure patterns so that each State will not significantly be over or under its final Federal fiscal year 1993 DSH allotment when the final reconciliation process takes place.

Those States that have overspent their final DSH allotment will have those expenditures in excess of that allotment disallowed. The expenditures that are disallowed will be subject to the normal disallowance procedures. Thus, the States may appeal to the Departmental Appeals Board and have the option to retain the funds during the appeal process.

We are adding a new § 447.298, State disproportionate share hospital allotments, to explain the calculation of a State's DSH allotment. New § 447.298(a)(1) describes the calculation of State base allotments for Federal fiscal year 1993. Each State's base DSH allotment is calculated using the greater of:

- The State's allowable DSH payments during the Federal fiscal year 1992 (beginning on October 1, 1991); or
- $1 Million.

In calculating the DSH payments during Federal fiscal year 1992, HCFA will derive these DSH amounts from payment plans which meet the requirements for FFP during the period from January 1, 1992 through September 30, 1992. This calculation will have the effect of removing, for purposes of calculating the State base allotment, any payments made under plans effective October 1, 1991 or later, which are not eligible for FFP after January 1, 1992. In addition, any retroactive DSH payments made in 1992 which were not applicable to Federal fiscal year 1992 will also be removed.

Under new § 447.299(a)(3), HCFA will calculate for each State the percentage of total medical assistance payments (excluding administrative costs) during Federal fiscal year 1992 which were DSH payment adjustments. HCFA will classify a State as a "high-DSH" State if its State base allotment exceeds 12 percent of total medical assistance expenditures in Federal fiscal year 1992. If its base allotment was 12 percent or less, the State will be considered a "low-DSH" State.

New § 447.298(b), State disproportionate share hospital allotments for Federal fiscal year 1993, provides requirements for State DSH allotments in Federal fiscal year 1993 for both high-DSH and low-DSH States. For a high-DSH State (i.e., one with a base-year allotment which is in excess of 12 percent of the current fiscal year's medical assistance expenditures), the dollar amount of DSH payments in any Federal fiscal year may not exceed the dollar amount of payments made in Federal fiscal year 1992. For example, if 12 percent of a State's base allotment were $1,000,000 and the State in Federal fiscal year 1992 had made DSH payments allowable under § 447.296 of $2,000,000, the State's aggregate DSH payments would be limited to $2,000,000 for Federal fiscal year 1993 and subsequent Federal fiscal years until its base allotment falls to or below 12 percent.

For a low-DSH State with a base year allotment of 12 percent or less, the allotment in Federal fiscal year 1993 will be calculated by HCFA by increasing the base allotment by a dollar amount equivalent to the following: (1) The State's growth in total medical assistance expenditures, including all administrative expenditures; and (2) a supplemental amount, if available under the national cap.

New § 447.298(c), State disproportionate share hospital allotment for Federal fiscal years 1994 and after, provides requirements for high-DSH and low-DSH States concerning DSH allotments for Federal fiscal years 1994 and after. For a State with a base-year allotment in excess of 12 percent of total medical assistance expenditures, the dollar amount of DSH payments in any Federal fiscal year may not exceed the dollar amount of payments made in Federal fiscal year 1992 until the year in which those payments, expressed as a percentage of total medical assistance expenditures, equals 12 percent or less. For a State with a base year allotment of 12 percent or less, the allotment in Federal fiscal year 1994 will be calculated by HCFA by increasing the prior year base DSH allotment by (1) State growth, and (2) a supplemental amount referred to as an amount from a redistribution pool, if available.

New § 447.298(d), State growth, describes the calculations for the amount of growth in State medical assistance expenditures that is permitted for a State in a Federal fiscal year. Under this section, the State growth for a State in a fiscal year is equal to the product of:

The State growth factor, which is the projected percentage increase in the State's total medical assistance expenditures (including all administrative expenditures) relative to the corresponding State medical assistance expenditures in the previous Federal fiscal year, as adjusted by HCFA; and

The State's prior year DSH allotment.

If there is no growth in a State's projected medical assistance expenditures over those in the previous year, the growth factor would be zero and the State's growth would also be zero. If the State's growth factor is negative, the amount is deducted from the State's prior year's DSH allotment. To do otherwise would negatively impact all other States. We specifically seek public comments on this approach.

New § 447.298(e), Supplemental amount, specifies that a supplemental amount is the State's share of a pool of money (referred to as a redistribution pool). The redistribution pool is calculated by HCFA for the appropriate Federal fiscal year by subtracting from the projected national DSH cap (12 percent of projected medical assistance expenditures) the following:

The total of the States' base allotments for all high-DSH States;

The total of the previous year's DSH allotments for all low-DSH States;

The State growth for all low-DSH States; and

Any additional amounts attributable to a State increasing payments to meet the minimum payment requirements of section 1923(c)(1) of the Act which are made in accordance with § 447.296(b)(5).

As mentioned earlier in the preamble, for a high-DSH State with a State base allotment in excess of 12 percent of current medical assistance expenditures, the dollar amount of the State's DSH payments in any fiscal year may not exceed the dollar amount of DSH payments made in Federal fiscal year 1992. High-DSH States are not entitled to receive any supplemental amounts or any growth amounts. A low-DSH State's share of the redistribution pool is calculated based on the State's relative share of total medical assistance expenditures projected to be made by low-DSH States. For example, if 100 percent of projected medical assistance expenditures for all low-DSH States is $1,000,000, while projected expenditures for one State is $100,000 or 10 percent, that State would be entitled to 10 percent of the monies available in the redistribution pool. In no event will a State receive a supplemental amount that would result in its DSH allotment exceeding 12 percent of projected medical assistance expenditures.

Any amounts not allocated to States because of this limitation will be allocated to other low-DSH States in accordance with their share of medical assistance expenditures. The difference between a State's actual DSH payments and its base allotment is not reallocated to low-DSH States.

A new § 447.298(f), Special provision, describes a special rule which applies to States that amend their State plans to meet the minimum payment requirements of section 1923(c)(1) of the Act, as previously described in § 447.296 of this interim rule. For these States, the State DSH allotment may not be less than the minimum payment adjustment, defined in § 447.296(b)(5). However, notwithstanding a State's current DSH allotment, any increases in a State's aggregate DSH payments that are made in accordance with the minimum payment requirements described in § 447.296(b)(5) may exceed the State base allotment to the extent such increases are made solely to satisfy the section 1923(c)(1) minimum payment requirement. In such cases, HCFA will adjust the State's base allotment in the subsequent Federal fiscal year to include the increased minimum payments. We believe that these payment increases should not be subject to the DSH allotment for the years the minimum payments are made, since section 1923(f)(1) of the Act specifically permits States to revise payment adjustments in order to pay the minimum adjustment required by section 1923(c)(1) of the Act.

In our discussion of the new § 447.296, we explain the calculation of the minimum payment required by section 1923(c)(1) of the Act. State plan amendments that are submitted to comply with these minimum payment requirements are permitted during the moratorium period. In this regard, we believe it is necessary that we permit this exception to the payment limit. As the result of permitting this exception, it is only fair and equitable that payment increases made solely for purposes of satisfying the minimum payment requirements of section 1923(c)(1) of the Act should be included in the calculation of State base allotments.

States permitted to amend their plans under § 447.298(f) after October 1, 1992 would have the DSH allotment increased to the minimum amount for the remainder of the Federal fiscal year in which the plan was approved. In the following year, a State's DSH allotment calculation would be based on the projected amount of payments under the approved plan.

A new § 447.298(g), National limit adjustment, has been added to explain that, in the event the aggregate amount of the State DSH allotments for any Federal fiscal year, beginning October 1, 1992, exceeds 12 percent of the total amount of medical assistance expenditures (excluding administrative costs) projected to be made during that fiscal year, each State's DSH allotment will be reduced proportionally to ensure that the 12 percent statutory cap is not exceeded.

Section 1903(d) of the Act was also amended by section 4 of Public Law 102–234, to require that each State must submit to the Secretary information related to the total amount of DSH payment adjustments made, and the amount of DSH payment adjustments made to individual providers, by the State, under section 1923(c) of the Act during the Federal fiscal year. This provision is effective for Federal fiscal years beginning in Federal fiscal year 1993.

Accordingly, we are adding a new § 447.299, Reporting requirements, which requires that each State submit to HCFA on a quarterly basis the aggregate amount of its DSH payments made to individual public and private facilities for each DSH program in effect. This reporting provision is effective beginning with the first quarter of Federal fiscal year 1993. Each State must provide this aggregate DSH information with its regular quarterly

budget and expenditure reporting in accordance with the forms and procedures established by HCFA in section 2600 of the State Medicaid Manual. Information on DSH payments made during Federal fiscal year 1992 was obtained in a request made on May 6, 1992, to the States for purposes of calculating the applicable State DSH base allotments. Instead of continuing this type of reporting process, we have incorporated this reporting into the States' normal budget and expenditure reporting processes and cycles. While we are requiring States only to report aggregate DSH information on a quarterly basis for each DSH program in effect, States must maintain, in readily reviewable form, supporting documentation that provides a detailed description of each DSH program, the legal basis of each DSH program, and the amount of DSH payments made to each individual public and private facility each quarter. This information must be made available to Federal reviewers upon request.

States' reports must present a complete, accurate, and full disclosure of all of their DSH programs and expenditures. If a State fails to comply with the reporting requirements, future grant awards will be reduced by the amount of FFP HCFA estimates is attributable to the expenditures made to the disproportionate share hospitals as to which the State has not reported properly, until such time as the State complies with the reporting requirements. Deferrals and/or disallowances of equivalent amounts may also be imposed with respect to quarters for which the State has failed to report properly. Unless otherwise prohibited by law, FFP for those expenditures will be released when the State complies with all reporting requirements.

In addition to the above changes, we are revising paragraph (c) of § 447.272, Application of upper payment limits, to cross-reference the applicable limitations in §§ 447.296 through 447.299. We have added a requirement that States must submit a separate upper payment limit assurance that its aggregate DSH payments do not exceed the applicable DSH payment limits.

IV. Waiver of Proposed Rulemaking

Section 5 of Public Law 102–234 provides specific authority for the issuance of interim final rules as necessary to implement provisions of Public Law 102–234. We are exercising our authority under section 5 in this instance by issuing this rule as an interim final rule. However, we are providing a 60-day comment period for public comments on this interim final rule as indicated at the beginning of this document.

V. Regulatory Impact Statement

Introduction

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a regulatory impact analysis for any interim final rule that meets one of the E.O. 12291 criteria for a "major rule"; that is likely to result in—

An annual effect on the economy of $100 million or more;

A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Execuive Order 12612 (E.O. 12612) requires us to prepare an analysis of any regulation or other policy statement or action that is likely to have substantial direct effects on the operations of State or local governments, limit State discretion in the administration of programs, or preempt State laws.

In addition, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that an interim final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we do not consider States or individuals to be small entities. However, we do consider all providers to be small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any interim final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

For the most part, these provisions merely conform the regulations to the legislative provisions of Pub. L. 102–234. However, we recognize that some of the provisions in this interim final rule with comment could be controversial and may be responded to unfavorably by some affected entities. We also recognize that not all of the potential effects of these provisions can be definitively anticipated. In light of this, we are doing a voluntary regulatory impact analysis. Furthermore, since this interim final rule with comment could have a significant economic impact on some small entities, we are preparing a voluntary analysis to conform to the objectives of E.O. 12612, the RFA, and section 1102(b) of the Act.

Effect on Program Expenditures

In the last several years, States have increased dramatically their use of donations or other voluntary payments and tax payments from health care providers to increase the Federal share of medical assistance expenditures. The primary use of these funds is to sustain large DSH payments which, prior to Public Law 102–234, were unlimited.

This interim final rule with comment interprets how States are to implement Public Law 102–234, which establishes new limitations on FFP when States receive funds donated from providers and revenues generated by certain health care-related taxes. The statute also establishes limits on the amount of payment adjustments to DSHs for which FFP is available. The provisions of the new law affecting taxes, donations, and DSH payments apply to all 50 States and the District of Columbia. However, the provisions do not apply to any State that operates its entire Medicaid program under a waiver granted under section 1115 of the Social Security Act.

There are specific provisions of Public Law 102–234 that apply to donations from providers and related entities, and to health care-related taxes. This law does not affect the treatment of donations from other entities not related to providers, or the receipt of revenues from generally applicable taxes. However, any revenues received by a State from the donations or taxes described in the Medicaid statute (title XIX of the Social Security Act) are subject to its provisions, without regard to whether these funds were directly or indirectly received by the Medicaid agency or some other department of the State or local government.

Under Public Law 102–234, a reduction in FFP will occur if States receive donations (except bona fide and outstationed eligibility worker donations) made by, or on behalf of, health care providers. The law also establishes a definition of the types of health care-related tax revenues States are permitted to receive without a reduction in FFP. Such taxes are broad-based taxes that apply to all health care providers in a given class in a uniform manner and that do not hold providers harmless for their tax costs. However, the law permits States that have, by

specified dates prior to the enactment of Public Law 102–234, received provider donations and taxes that are not permitted by this law, to continue to receive them for a limited time without a reduction in FFP.

We believe there is no direct budgetary impact from the changes implemented by this law and the final regulations. The current Federal Medicaid baseline spending projections already incorporate estimates made after the enactment of Public Law 102–234. The following table shows amounts included in the fiscal year 1993 Federal Medicaid budget associated with State tax and donation programs. These projections were derived from estimates provided by States. At the current time, these amounts must be considered upper bounds since we do not know whether States will be able to sustain the current level of tax and donation funding activity in the future under the requirements of Public Law 102–234.

Projected Federal Medicaid Spending Associated with State Provider Tax and Donation Programs

[In billions of dollars]

Fiscal year:	*Amount*
1992	8.7
1993	11.3
1994	14.4
1995	18.0
1996	22.0

Public Law 102–234 also imposes limits on DSH payments. One limit is applicable to the period from January 1, 1992 through September 30, 1992. This limit, in effect, imposes a moratorium on changes to States' DSH payment methodologies. The statute specifies that States may not receive FFP for DSH payments unless the payments were made in accordance with a State plan in effect or plan amendments submitted prior to certain dates and which meet certain other requirements, as previously discussed in this preamble.

A second limit goes into effect on October 1, 1992. This limit establishes both national and States limits on DSH payments for each Federal fiscal year. The national limit is established at 12 percent of total medical assistance expenditures (excluding administrative costs) for all States in a Federal fiscal year. The State limit is similarly set at 12 percent of a State's medical assistance expenditures (excluding administrative costs) in a fiscal year. States with DSH payments above the 12 percent limit will not be able to increase aggregate DSH payments. States with DSH payments below the limit will be permitted to increase payments to the extent their Medicaid programs grow and to the extent national DSH payments do not exceed the 12 percent limit. A preliminary national DSH limit and preliminary State-specific DSH allotments are calculated prospectively, before the beginning of the Federal fiscal year, and will be published in the **Federal Register** prior to October 1 of each year. These preliminary calculations will be updated and published in the **Federal Register** by April 1 of each year and subsequently reconciled to actual expenditures by April 1 of the following year. In calculating both the preliminary and final limits, DSH expenditures will be capped at 12 percent in accordance with the statutory requirements. If, in any year, DSH expenditures exceed 12 percent, HCFA will proportionally reduce the State DSH allotments for all States to ensure that the cap does not exceed the 12-percent statutory limit.

We believe there is no direct budgetary impact from the changes implemented by this law and the final regulations. The current Federal Medicaid baseline spending projections already incorporate estimates made after the enactment of Pub. L. 102–234. The following table displays projections of Federal DSH payments included in the fiscal year 1993 President's budget. These projections are based on State estimates and reflect the limits established by Public Law 102–234. Since much of DSH spending is currently supported by tax and donation programs, the extent to which these payment levels will be maintained by States under the restrictions on such programs imposed by Public Law 102–234 is uncertain.

Projected Federal DSH Payments Under Pub. L. 102–234

[In billions of dollars]

Fiscal year:	*Amount*
1992	8.4
1993	9.5
1994	11.1
1995	12.9
1996	15.0

Effect on States, Providers and Recipients

As a result of this interim final rule with comment, States may, with certain limitations, continue to receive donations or other voluntary payments, as well as revenues from health care-related taxes. Some States have directly linked donation and other voluntary payment programs to increases in Medicaid hospital payment rates. Other States have levied taxes or other mandatory payments on providers and modified Medicaid payment rates in such a way as to reimburse the provider for the cost of the tax. Thus, it might be argued that this interim final rule with comment could limit providers in their opportunities to receive increased payments for services furnished to Medicaid recipients. We concede that in some cases this might be true, but only to the extent that the State is unable to find legitimate alternative sources of State funds to finance these increases in payment rates.

We expect the following associated State costs as a result of these provisions:

Projected State Medicaid Spending Associated With State Provider Tax and Donation Programs

[In billions of dollars]

Fiscal year:	*Amount*
1992	6.5
1993	8.5
1994	10.8
1995	13.5
1996	16.5

Projected State DSH Payments Under Pub. L. 102–234

[In billions of dollars]

Fiscal year:	*Amount*
1992	6.3
1993	7.0
1994	8.2
1995	9.5
1996	11.0

We do not expect this rule to have either a direct or indirect effect on recipients since this rule will not preclude providers from receiving Medicaid payments for services that were already being furnished.

Conclusion

In keeping with the requirements of E.O. 12612, we were presented with a problem of national scope—that is, how to continue the taxes and donations program without infringing on States' rights or bankrupting the Medicaid program. However, we believe that the provisions in Public Law 102–234 will, to a large extent, curtail this problem. Therefore, in accordance with the law, we are requiring a cap on provider donations and health care-related taxes that can be calculated as the State's share of financial participation, and on the amount of payments to DSHs.

This interim final rule with comment will in no way preclude States from increasing their share of Medicaid

expenditures from other funding sources. Moreover, with regard to DSH payments, this interim final rule with comment places a limit solely on the amount of DSH payments States are permitted to make. States designated as "high DSH" States will continue to receive the same dollar amount previously expended for DSH payments. States designated as "low DSH" States will be entitled to receive the amount received in the preceding period plus a growth amount from the redistribution pool. We emphasize that this rule in no way restricts States' flexibility in defining DSHs.

VI. Collection of Information Requirements

Sections 433.54(a), 433.55(b), 433.58(e), 433.60 (b) and (d), 433.68 (e) and (f), 433.70(a)(2), 433.72, 433.74, 447.272(c), 447.296(b)(6), and 447.299 of this interim final rule contain information collection or recordkeeping requirements, or both, that are subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*). The information collection requirements concern the collection of data to ensure that the aggregate limit for DSH payments is not exceeded and to establish the amount of provider-related donations and health care-related taxes States are permitted to receive without a reduction in FFP. The respondents who will provide the information include State Medicaid agencies. Public reporting burden for this collection of information is estimated to be minimal, as discussed below.

Section 1903(d) of the Act explicitly requires States to report to the Secretary at the end of each fiscal year information about (1) provider-related donations made to States or units of local government, (2) health care-related taxes collected by States or such units, and (3) the total amount of DSH payment adjustments made to individual providers. We do not believe these reporting requirements, which are incorporated in our regulations at §§ 433.74 and 447.299, will burdensome to States since the data are already available. The only burden to States will be in formatting their data to conform to newly revised HCFA quarterly budget reports. We estimate the amount of additional time needed to report this data to be 112 hours annually per State, resulting in a total of 5,712 hours for all States.

Since States have been making DSH payments in accordance with section 1923 of the Act since July 1988, State DSH expenditures are already recorded and available on quarterly budget reports. Therefore, these regulations will not impose new burden requirements on States. Moreover, States currently are required to provide assurances with their State plans. The addition of the new DSH payment assurance described in § 447.272(c) should take States no more than a quarter hour to prepare for each inpatient hospital payment plan submitted. The requirement in § 447.296(b)(6) should take States no more than 2 hours per inpatient hospital payment plan submitted since States merely need to show HCFA the redistribution of DSH payments based on their own DSH data.

Section 433.54(a) defines bona fide donations. We were aware of the potential administrative burden on States in requiring them to receive "advance approval" from HCFA for each donation received. Consequently, we have determined that the types of provider-related donations that we will presume to be bona fide are those voluntary payments, including, but not limited to gifts, contributions, presentation or awards, made by or on behalf of individual health care providers to the State county or any other unit of local government that do not exceed $5,000. In the case of an institutional provider, the donation could not exceed $50,000. A donation amount that exceeds the monetary cap will require explicit authorization from HCFA prior to being considered bona fide. We are unable to determine the burden on States on meeting this requirement since we are unable to estimate how many States will receive provider donations in excess of the monetary threshold established.

To the extent that States impose taxes that require them to determine if the tax is health care related, as defined in § 433.55(b) (i.e., to calculate if 85 percent of the burden of the tax falls on health care providers), States will incur a limited recordkeeping burden. States are not required to obtain "advance approval" of State tax programs. States need only be able to demonstrate that their tax programs comply with the law. We are unable to determine the degree of this recordkeeping burden on States since we cannot estimate States tax initiatives that would be subject to this provision.

Additionally, we are unable to forecast how many States will elect to receive donations from providers for the direct costs of outstanding eligibility workers. However, we do not believe that the data required from States in §§ 433.60(d) and 433.70(a)(2) to compute the amount of provider donations States may receive for the direct costs of outstationed eligibility workers will be burdensome to States. Only those States that receive provider donations from facilities for the direct costs of outstationed eligibility workers need to report this information. In these cases, these data are already available. The only burden to States will be in formatting their data to conform to newly revised HCFA quarterly budget reports.

Section 1903(w)(5) of the Act permits all States to have a transition cap of 25 percent. The information required in § 433.60(b) to determine the amount of the 25 percent transition cap is available on quarterly budget documents already submitted to HCFA by States. Only those States that believe they qualify for a transition cap greater than 25 percent (i.e., a State base percentage) need to submit applicable financial documentation to HCFA. We do not know how many States will qualify for a State base percentage, nor are we able to predict how many will elect to demonstrate this to HCFA. Consequently, we are unable to estimate the impact of this requirement. However, computing the State base percentage is a one-time calculation. Sections 433.58 (e) and (g) make clear that States will not be required to create new or special documentation to illustrate that impermissible donation programs and provider-specific taxes qualify for a State base percentage that is greater than 25 percent. Rather, States are only required to submit documents already in existence which support that applicability of the State base percentage.

Finally, § 433.72 provides States with the option of requesting a waiver of certain provisions applicable to health care-related taxes. We are unable to estimate what impact this provision will have on States since we do not know how many States will enact legislation that will require a waiver. However, we estimate that each waiver request will require 100 hours of additional time. Moreover, States are not required to obtain advance approval of tax programs and some States may elect not to request a waiver of a nonconforming tax program although remaining at risk. We believe the information required to satisfy the waiver requirements will not be burdensome to States since this information is already available and the State need only format this data to show how the waiver requirements are met.

A notice will be published in the **Federal Register** when OMB approval is obtained. Other organizations and individuals desiring to submit comments regarding the estimate or any other

aspect of this collection of information, including suggestions for reducing this burden, should address their comments to the OMB official whose name appears in the "ADDRESSES" section of this preamble.

VII. Response to Public Comments

Because of the large volume of public comments that we usually receive on rules, we cannot acknowledge or respond to them individually. However, we will address all public comments that we receive by the date specified in the "DATES" section of this preamble and respond to them in the preamble to the subsequent final rule that we issue.

List of Subjects

42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs-health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs-health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

42 CFR chapter IV, subchapter C is amended as follows:

A. Part 433 is amended as follows:

PART 433—STATE FISCAL ADMINISTRATION

1. The authority citation for part 433 is revised to read as follows:

Authority: Secs. 1102, 1902(a)(4), 1902(a)(18), 1902(a)(25), 1902(a)(45), 1902(t), 1903(a)(3), 1903(d)(2), 1903(d)(5), 1903(i), 1903(o), 1903(p), 1903(r), 1903(w), 1912, and 1917 of the Social Security (42 U.S.C. 1302, 1396a(a)(4), 1396a(a)(18), 1396a(a)(25), 1396a(a)(45), 1396a(t), 1396b(a)(3), 1396b(d)(2), 1396b(d)(5), 1396b(o), 1396b(p), 1396b(r), 1396b(w), 1396k and 1396(p)).

2. The heading for subpart A is revised to read as follows:

Subpart A—Federal Matching and General Administration Provisions

3. Sections 433.32, 433.34, 433.35, 433.36, 433.37, 433.38, and 433.40 are transferred from subpart B to subpart A.

4. Subpart B, consisting of §§ 433.50 through 433.74, is revised to read as follows:

Subpart B—General Administrative Requirements State Financial Participation

Sec.

§ 433.50 Basis, scope, and applicability.

(a) *Basis.* This subpart interprets and implements—

(1) Section 1902(a)(2) of the Act, which requires States to share in the cost of medical assistance expenditures and permits both State and local governments to participate in the financing of the non-Federal portion of medical assistance expenditures.

(2) Section 1903(a) of the Act, which requires the Secretary to pay each State an amount equal to the Federal medical assistance percentage of the total amount expended as medical assistance under the State's plan.

(3) Section 1903(w) of the Act, which specifies the treatment of revenues from provider-related donations and health care-related taxes in determining a State's medical assistance expenditures for which Federal financial participation (FFP) is available under the Medicaid program.

(b) *Scope.* This subpart—

(1) Specifies State plan requirements for State financial participation in expenditures for medical assistance.

(2) Defense provider-related donations and health care-related taxes that may be received without a reduction in FFP.

(3) Specifies rules for revenues received from provider-related donations and health care-related taxes during a transition period.

(4) Establishes limitations on FFP when States receive funds from provider-related donations and revenues generated by health care-related taxes.

(c) *Applicability.* The provisions of this subpart apply to the 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act.

§ 433.51 Public funds as the State share of financial participation.

(a) Public funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.

(b) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.

(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

§ 433.52 General definitions.

As used in this subpart—

Entity related to a health care provider means—

(1) An organization, association, corporation, or partnership formed by or on behalf of a health care provider;

(2) An individual with an ownership or control interest in the provider, as defined in section 1124(a)(3) of the Act;

(3) An employee, spouse, parent, child, or sibling of the provider, or of a person with an ownership or control interest in the provider, as defined in section 1124(a)(3) of the Act; or

(4) A supplier of health care items or services or a supplier to providers of health care items or services.

Health care provider means the individual or entity that receives any payment or payments for health care items or services provided.

Provider-related donation means a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a State or unit of local government by or on behalf of a health care provider, an entity related to such a health care provider, or an entity providing goods or services to the State for administration of the State's Medicaid plan.

(1) Donations made by a health care provider to an organization, which in turn donates money to the State, may be considered to be a donation made indirectly to the State by a health care provider.

(2) When an organization receives less than 25 percent of its revenues from providers and/or provider-related entities, its donations will not generally be presumed to be provider-related donations. Under these circumstances, a

provider-related donation to an organization will not be considered a donation made indirectly to the State. However, if the donations from providers to an organization are subsequently determined to be indirect donations to the State or unit of local government for administration of the State's Medicaid program, then such donations will be considered to be health care related.

(3) When the organization receives more than 25 percent of its revenue from donations from providers or provider-related entities, the organization always will be considered as acting on behalf of health care providers if it makes a donation to the State. The amount of the organization's donation to the State, in a State fiscal year, that will be considered health care related, will be based on the percentage of donations the organization received from the providers during that period.

§ 433.53 State financial participation.

A State plan must provide that—

(a) State (as distinguished from local) funds will be used both for medical assistance and administration;

(b) State funds will be used to pay at least 40 percent of the non-Federal share of total expenditures under the plan; and

(c) State and Federal funds will be apportioned among the political subdivisions of the State on a basis that assures that—

(1) Individuals in similar circumstances will be treated similarly throughout the State; and

(2) If there is local financial participation, lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of services or level of administration under the plan in any part of the State.

§ 433.54 Bona fide donations.

(a) A bona fide donation means a provider-related donation, as defined in § 433.52, made to the State or unit of local government, that has no direct or indirect relationship, as described in paragraph (b) of this section, to Medicaid payments made to—

(1) The health care provider;

(2) Any related entity providing health care items and services; or

(3) Other providers furnishing the same class of items or services as the provider or entity.

(b) Provider-related donations will be determined to have no direct or indirect relationship to Medicaid payments if those donations are not returned to the individual provider, the provider class, or related entity under a hold harmless provision or practice, as described in paragraph (c) of this section.

(c) A hold harmless practice exists if any of the following applies:

(1) The amount of the payment received (other than under title XIX of the Act) is positively correlated either to the amount of the donation or to the difference between the amount of the donation and the amount of the payment received under the State plan;

(2) All or any portion of the payment made under Medicaid to the donor, the provider class, or any related entity, varies based only on the amount of the total donation received; or

(3) The State or other unit of local government receiving the donation provides for any payment, offset, or waiver that guarantees to return any portion of the donation to the provider.

(d) HCFA will presume provider-related donations to be bona fide if the voluntary payments, including, but not limited to, gifts, contributions, presentations or awards, made by or on behalf of individual health care providers to the State, county, or any other unit of local government does not exceed—

(1) $5,000 per year in the case of an individual provider donation; or

(2) $50,000 per year in the case of a donation from any health care organizational entity.

(e) To the extent that a donation presumed to be bona fide contains a hold harmless provision, as described in paragraph (c) of this section, it will not be considered a bona fide donation. When provider-related donations are not bona fide, HCFA will deduct this amount from the State's medical assistance expenditures before calculating FFP. This offset will apply to all years the State received such donations and any subsequent fiscal year in which a similar donation is received.

§ 433.55 Health care-related taxes defined.

(a) A health care-related tax is a licensing fee, assessment, or other mandatory payment that is related to—

(1) Health care items or services;

(2) The provision of, or the authority to provide, the health care items or services; or

(3) The payment for the health care items or services.

(b) A tax will be considered to be related to health care items or services under paragraph (a)(1) of this section if at least 85 percent of the burden of the tax revenue falls on health care providers.

(c) A tax is considered to be health care related if the tax is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different than the tax treatment provided to other individuals or entities.

(d) A health care-related tax does not include payment of a criminal or civil fine or penalty, unless the fine or penalty was imposed instead of a tax.

(e) Health care insurance premiums and health maintenance organization premiums paid by an individual or group to ensure coverage or enrollment are not considered to be payments for health care items and services for purposes of determining whether a health care-related tax exists.

§ 433.56 Classes of health care services and providers defined.

(a) For purposes of this subpart, each of the following will be considered as a separate class of health care items or services:

(1) Inpatient hospital services;

(2) Outpatient hospital services;

(3) Nursing facility services (other than services of intermediate care facilities for the mentally retarded);

(4) Intermediate care facility services for the mentally retarded, and similar services furnished by community-based residences for the mentally retarded, under a waiver under section 1915(c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/MRs prior to the grant of the waiver;

(5) Physician services;

(6) Home health care services;

(7) Outpatient prescription drugs;

(8) Services of health maintenance organizations and health insurance organizations; and

(9) Other health care items or services not listed above on which the State has enacted a licensing or certification fee, subject to the following:

(i) The fee must be broad based and uniform or the State must receive a waiver of these requirements;

(ii) The payer of the fee cannot be held harmless; and

(iii) The aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program.

(b) Taxes that pertain to each class must apply to all items and services within the class, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider.

§ 433.57 General rules regarding revenues from provider-related donations and health care-related taxes.

Effective January 1, 1992, HCFA will deduct from a State's expenditures for

medical assistance, before calculating FFP, funds from provider-related donations and revenues generated by health care-related taxes received by a State or unit of local government, in accordance with the requirements, conditions, and limitations of this subpart, if the donations and taxes are not—

(a) Donations and taxes that meet the requirements specified in § 433.58, except for certain revenue received during a specified transition period;

(b) Permissible provider-related donations, as specified in § 433.66(b); or

(c) Health care-related taxes, as specified in § 433.68(b).

§ 433.58 Provider-related donations and health care-related taxes during a State's transition period.

(a) *General rule.* During the State's transition period specified in paragraph (b) of this section, a State may receive certain provider-related donations and health care-related taxes without a reduction in FFP. These provider-related donations and health care-related taxes must meet the conditions specified in this section and are subject to limitations specified in § 433.60.

(b) *Transition periods for States.*

(1) Except as provided in paragraph (b)(2) of this section, the provisions of this section apply for the period beginning January 1, 1992 and ending—

(i) September 30, 1992, for States whose State fiscal year begins on or before July 1, 1992; or

(ii) December 31, 1992, for States whose State fiscal year begins after July 1, 1992.

(2) The provisions of this section apply for the period beginning January 1, 1992 and ending June 30, 1993 for States that—

(i) Are not scheduled to have a regular legislative session in calendar year 1992;

(ii) Are not scheduled to have a regular legislative session in calendar year 1993; or

(iii) Had enacted a health care-related tax program on November 4, 1991.

(c) *Provider-related donations during the transition period.* Subject to the limitations specified in § 433.60, a State may receive, without a reduction in FFP, provider-related donations described in paragraph (d)(3) of this section during the applicable transition period.

(d) *Permissible donations.* To be permissible donations, the donations must be—

(1) Bona fide donations, as defined in § 433.54;

(2) Donations made by a hospital, clinic, or similar entity (such as a Federally-qualified health center) for the direct costs of State or local agency personnel who are stationed at that facility to determine the eligibility (including eligibility redeterminations) of individuals for Medicaid and/or to provide outreach services to eligible (or potentially eligible) Medicaid individuals. Direct costs of outstationed eligibility workers refers to the costs of training, salaries and fringe benefits associated with each outstationed worker and similar allocated costs of State or local agency support staff, and a prorated cost of pamphlets and materials distributed by the outstationed workers at these sites. Costs for such items as State agency overhead, advertising campaigns, and provider office space are not allowable direct costs for this purpose; or

(3) Provider-related donations, even if the donations do not qualify under the provisions of paragraph (d) (1) or (2) of this section, that meet the following conditions:

(i) The donation program was in effect on September 30, 1991, described in State plan amendments or related documents submitted to HCFA by that date, or substantiated by written documentary evidence (as described in paragraph (e) of this section) that was in existence as of that date; and

(ii) The donation program is applicable to the State's fiscal year 1992, as demonstrated by written documentary evidence as described in paragraph (e) of this section.

(e) *Written documentary evidence.* The State must have written documentation, which was in existence on September 30 1991, of a donation program described in paragraph (d)(3) of this section that includes the dollar amounts it received in State fiscal year 1992 and the amounts it intended to receive, as evidenced by one or more of the following:

(1) Reference to a donation program in a State plan amendment or related documents, including a satisfactory response, as determined by HCFA, to a HCFA request for additional information;

(2) State budget documents identifying the amounts States expected to be received in donations;

(3) Written agreements with the parties donating the funds; and/or

(4) Other written documents that identify amounts that the States planned to receive in donations from specified organizations during that period.

(f) *Application of rules to State fiscal year 1993.* For any portion of a State's fiscal year 1993 that occurs during the transition period, the State may receive, without a reduction in FFP, the amount of provider-related donations that it received in the corresponding period in State fiscal year 1992, including the 5 days after the end of that period, subject to the limitations specified in 433.60(a).

(g) *Health care-related taxes during the transition period.* (1) Subject to the limitations specified in § 433.60, States may receive, without a reduction in FFP, health care-related taxes during the State's transition period if:

(i) The health care-related taxes are broad-based and uniformly imposed, and the taxpayer will not be held harmless, as specified in § 433.68; or

(ii) The health care-related taxes are imposed under—

(A) A tax program that was in effect as of November 22, 1991; or

(B) Legislation or regulations that were enacted or adopted as of November 22, 1991.

(2) A State may not modify health care-related taxes in existence as of November 22, 1991, without a reduction of FFP, unless the modification only—

(i) Extends a tax program that was scheduled to expire before the end of the State's transition period;

(ii) Makes technical changes that do not alter the rate of the tax or the base of the tax (e.g., the providers on which the tax is imposed and do not otherwise increase the proceeds of the tax; or

(iii) Decreases the rate of the tax, without altering the base of the tax.

§ 433.60 Limitations on level of FFP in State expenditures from provider-related donations and health care-related taxes during the transition period.

(a) *Maximum amounts.* The maximum amount of total provider-related donations, as specified in § 433.58(d)(3), and health care-related taxes that a State may receive without a reduction in FFP during a State fiscal year in the State's transition period specified in § 433.58(b) is calculated by multiplying—

(1) The State's total medical assistance expenditures for the fiscal year; by

(2) The greater of:

(i) 25 percent; or

(ii) The "State base percentage" (as described in paragraph (b) of this section).

(b) *State base percentage.*

(1) The State's base percentage is calculated by dividing the amount of the provider-related donations and health care-related taxes identified in § 433.58 and estimated by HCFA to be received in the State's fiscal year 1992 by the total non-Federal share of medical assistance expenditures (including administrative costs) in that fiscal year based on the best available HCFA data.

(2) In calculating the amount of taxes specified in paragraph (b)(1)(i) of this section, taxes (including the tax rate or base) that were not in effect for the entire State fiscal year, but for which legislation or regulations imposing such taxes were enacted or adopted as of November 22, 1991, will be estimated as if they were in effect for the entire fiscal year.

(c) *Deductions before calculating FFP.* Before calculating FFP, HCFA will deduct from a State's medical assistance expenditures the total amount of any provider-related donations described in § 433.58(d)(3), and health care-related taxes in excess of the limit calculated under paragraph (a) of this section.

§ 433.66 Permissible provider-related donations after the transition period.

(a) *General rule.* (1) Except as specified in paragraph (a)(2) of this section, subsequent to the end of a State's transition period, as defined in § 433.58(b), a State may receive revenues from provider-related donations without a reduction in FFP, only in accordance with the requirements of this section.

(2) The provisions of this section relating to provider-related donations for outstationed eligibility workers are effective on October 1, 1992, whether or not the State's transition period continues beyond that date.

(b) *Permissible donations.* Subject to the limitations specified in § 433.67, a State may receive, without a reduction in FFP, provider-related donations that meet at least one of the following requirements:

(1) The donations must be bona fide donations, as defined in § 433.54; or

(2) The donations are made by a hospital, clinic, or similar entity (such as a Federally-qualified health center) for the direct costs of State or local agency personnel who are stationed at the facility to determine the eligibility (including eligibility redeterminations) of individuals for Medicaid or to provide outreach services to eligible (or potentially eligible) Medicaid individuals. Direct costs of outstationed eligibility workers refers to the costs of training, salaries and fringe benefits associated with each outstationed eligibility worker and similar allocated costs of State or local agency support staff, and a prorated cost of pamphlets and materials distributed by the outstationed workers at these sites. Costs for such items as State agency overhead, advertising campaigns, and provider space are not allowable for this purpose.

§ 433.67 Limitations on level of FFP for permissible provider-related donations.

(a)(1) *Limitations on bona fide donations.* There are no limitations on the amount of bona fide provider-related donations that a State may receive without a reduction in FFP, as long as the bona fide donations meet the requirements of § 433.66(b)(1).

(2) *Limitations on donations for outstationed eligibility workers.* Effective October 1, 1992, regardless of when a State's transition period ends, the maximum amount of provider-related donations for oustationed eligibility workers, as described in § 433.66(b)(2), that a State may receive without a reduction in FFP may not exceed 10 percent of a State's medical assistance administrative costs (both the Federal and State share), excluding the costs of family planning activities. The 10 percent limit for provider-related donations for outstationed eligibility workers is not included in the limit in effect through September 30, 1995, for health care-related taxes as described in § 433.70.

(b) *Calculation of FFP.* HCFA will deduct from a State's medical assistance expenditures, before calculating FFP, any provider-related donations that do not meet the requirements of § 433.66(b)(1) and provider donations for outstationed eligibility workers in excess of the limits specified under paragraph (a)(2) of this section.

§ 433.68 Permissible health care-related taxes after the transition period.

(a) *General rule.* Beginning on the day after a State's transition period, as defined in § 433.58(b), ends, a State may receive health care-related taxes, without a reduction in FFP, only in accordance with the requirements of this section.

(b) *Permissible health care-related taxes.* Subject to the limitations specified in § 433.70, a State may receive, without a reduction in FFP, health care-related taxes if all of the following are met:

(1) The taxes are broad based, as specified in paragraph (c) of this section;

(2) The taxes are uniformly imposed throughout a jurisdiction, as specified in paragraph (d) of this section; and

(3) The tax program does not violate the hold harmless provisions specified in paragraph (f) of this section.

(c) *Broad based health care-related taxes.*

(1) A health care-related tax will be considered to be broad based if the tax is imposed on at least all health care items or services in the class or providers of such items or services furnished by all non-Federal, non-public providers in the State, and is imposed uniformly, as specified in paragraph (d) of this section.

(2) If a health care-related tax is imposed by a unit of local government, the tax must extend to all items or services or providers (or to all providers in a class) in the area over which the unit of government has jurisdiction.

(3) A State may request a waiver from HCFA of the requirement that a tax program be broad based, in accordance with the procedures specified in § 433.72.

(d) *Uniformly imposed health care-related taxes.* A health care-related tax will be considered to be imposed uniformly even if it excludes Medicaid or Medicare payments (in whole or in part), or both; or, in the case of a health care-related tax based on revenues or receipts with respect to a class of items or services (or providers of items or services), if it excludes either Medicaid or Medicare revenues with respect to a class of items or services, or both.

(1) A health care-related tax will be considered to be imposed uniformly if it meets any one of the following criteria:

(i) If the tax is a licensing fee or similar tax imposed on a class of health care services (or providers of those health care items or services), the tax is the same amount for every provider furnishing those items or services within the class.

(ii) If the tax is a licensing fee or similar tax imposed on a class of health care items or services (or providers of those items or services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of those items or services in the class.

(iii) If the tax is imposed on provider revenue or receipts with respect to a class of items or services (or providers of those health care items or services), the tax is imposed at a uniform rate for all services (or providers of those items or services) in the class on all the gross revenues or receipts, or on net operating revenues relating to the provision of all items or services in the State, unit, or jurisdiction. Net operating revenue means gross charges of facilities less any deducted amounts for bad debts, charity care, and payer discounts.

(iv) The tax is imposed on items or services on a basis other than those specified in paragraphs (d)(1) (i) through (iii) of this section, e.g., an admission tax, and the State establishes to the satisfaction of the Secretary that the amount of the tax is the same for each provider of such items or services in the class.

(2) A tax imposed with respect to a class of health care items or services will not be considered to be imposed uniformly if it meets either one of the following two criteria:

(i) The tax provides for credits, exclusions, or deductions which have as its purpose, or results in, the return to providers of all, or a portion, of the tax paid, and it results, directly or indirectly, in a tax program in which—

(A) The net impact of the tax and payments is not generally redistributive, as specified in paragraph (e) of this section; and

(B) The amount of the tax is directly correlated to payments under the Medicaid program.

(ii) The tax holds taxpayers harmless for the cost of the tax, as described in paragraph (f) of this section.

(3) If a tax does not meet the criteria specified in paragraphs (d)(1)(i) through (iv) of this section, but the State establishes that the tax is imposed uniformly in accordance with the procedures for a waiver specified in § 433.72, the tax will be treated as a uniform tax.

(e) *Generally redistributive.* A tax will be considered to be generally redistributive if it meets the requirements of this paragraph. If the State desires waiver of only the broad-based tax requirement, it must demonstrate compliance with paragraph (e)(1) of this section. If the State desires waiver of the uniform tax requirement, whether or not the tax is broad-based, it must demonstrate compliance with paragraph (e)(2) of this section.

(1) *Waiver of broad-based requirement only.*

(i) A State seeking waiver of the broad-based tax requirement must demonstrate that its proposed tax plan meets the requirement that its plan is generally redistributive by:

(A) Calculating the proportion of the tax revenue applicable to Medicaid if the tax were broad based and applied to all providers or activities within the class (called P1);

(B) Calculating the proportion of the tax revenue applicable to Medicaid under the tax program for which the State seeks a waiver (called P2); and

(C) Calculating the value of P1/P2.

(ii) If the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is greater than 1, HCFA will automatically approve the waiver request. If the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.95 but is not greater than 1, HCFA will review the waiver request. Such a waiver will be approved only if the following two criteria are met:

(A) The value of P1/P2 is at least 0.95 and is not greater than 1; and

(B) The tax excludes or provides credits or deductions only to one or more of the following providers of items and services within the class to be taxes:

(1) Providers that furnish no services within the class in the State;

(2) Providers that do not charge for services within the class;

(3) Rural hospitals (defined as any hospital located outside of an urban area as defined in § 412.62(f)(1)(ii) of this chapter);

(4) Only sole community hospitals as defined in § 412.92(a) of this chapter;

(5) Physicians practicing primarily in medically underserved areas as defined in section 1302(7) of the Public Health Service Act.

(2) *Waiver of uniform tax requirement.* (i) A State seeking waiver of the uniform tax requirement (whether or not the tax is broad based) must demonstrate that its proposed tax plan meets the requirement that its plan is generally redistributive by:

(A) Calculating, using ordinary least squares, the slope (designated as (*B*) (i.e. the value of the x coefficient) of two linear regressions, in which the dependent variable is each provider's percentage share of the total tax paid by all taxpayers during a 12-month period, and the independent variable is the taxpayer's "Medicaid Statistic". The term "Medicaid Statistic" means the number of the provider's taxable units applicable to the Medicaid program during a 12-month period. If, for example, the State imposed a tax based on provider charges, the amount of a provider's Medicaid charges paid during a 12-month period would be its "Medicaid Statistic". If the tax were based on provider inpatient days, the number of the provider's Medicaid days during a 12-month period would be its "Medicaid Statistic". For the purpose of this test, it is not relevant that a tax program exempts Medicaid from the tax.

(B) Calculating the slope (designated as B1) of the linear regression, as described in paragraph (e)(2)(i) of this section, for the State's tax program, if it were broad based and uniform.

(C) Calculating the slope (designated as B2) of the linear regression, as described in paragraph (e)(2)(i) of this section, for the State's tax program, as proposed.

(ii) If the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is greater than 1, HCFA will automatically approve the waiver request. If the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least 0.95 but is not greater than 1, HCFA will review the waiver request. Such a waiver will be approved only if the following two criteria are met:

(A) The value of B1/B2 is at least 0.95 and is not greater than 1; and

(B) The tax excludes or provides credits or deductions only to one or more of the following providers of items and services within the class to be taxed:

(1) Providers that furnish no services within the class in the State;

(2) Providers that do not charge for services within the class;

(3) Rural hospitals (defined as any hospital located outside of an urban area as defined in § 412.62(f)(1)(ii)) of this chapter;

(4) Sole community hospitals as defined in § 412.92(a) of this chapter; or

(5) Physicians practicing primarily in medically underserved areas as defined in section 1302(7) of the Public Health Service Act.

(f) *Hold harmless.* A taxpayer will be considered to be held harmless under a tax program if any of the following conditions applies:

(1) The State (or other unit of government) imposing the tax provides directly or indirectly for a non-Medicaid payment to those providers or others paying the tax and the amount of the payment is positively correlated to either the amount of the tax or to the difference between the Medicaid payment and the total tax cost.

(2) All or any portion of the Medicaid payment to the taxpayer varies based only on the amount of the total tax payment.

(3) The State (or other unit of local government) imposing the tax provides, directly or indirectly, for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

(i) If an explicit guarantee does not exist, then a two-prong "guarantee" test will be applied. This specific hold harmless test will be effective December 24, 1992. In this instance, if the health care-related tax is applied at a rate that is less than or equal to 6 percent of the revenues received by the taxpayer, the tax is presumed to be permissible under this test. When the tax is applied at a rate in excess of 6 percent of the revenue received by the taxpayer, HCFA will consider a hold harmless provision to exist if 75 percent of the taxpayers in the class or classes receive 75 percent of their total tax costs back in enhanced Medicaid payments or other State payments. If this standard is violated, the amount of tax revenue to be offset from medical assistance

expenditures is the total amount of the taxpayers' revenues received by the State. Additionally, any tax in effect before April 1, 1993, containing an explicit guarantee will also be considered to violate the statutory hold harmless provision.

(ii) If, as of December 24, 1992, a State has enacted a tax in excess of 6 percent that does not meet the requirements in paragraph (f)(3)(i) of this section, HCFA will not disallow funds received by the State resulting from the tax if the State modifies the tax to comply with this requirement by April 1, 1993 the tax is not modified, funds received by States on or after April 1, 1993 will be disallowed.

§ 433.70 Limitations on level of FFP for revenues from health care-related taxes after the transition period.

(a) *Limitations.* (1) Subsequent to the end of a State's transition period (as defined in § 433.58(b)), and extending through September 30, 1995, the maximum amount of health care-related taxes specified in § 433.68 that a State may receive during a State fiscal year (or portion thereof), without a reduction in FFP, is limited to—

(i) The greater of 25 percent or the State base percentage as described in § 433.60(b); multiplied by

(ii) The State's share of total medical assistance expenditures for the State fiscal year, less all health care-related taxes other than those described in § 433.68 that are deducted separately pursuant to paragraph (b) of this section.

(2) Beginning October 1, 1995, there is no limitation on the amount of health care-related taxes that a State may receive without a reduction in FFP, as long as the health care-related taxes meet the requirements specified in § 433.68.

(b) *Calculation of FFP.* HCFA will deduct from a State's medical assistance expenditures, before calculating FFP, revenues from health care-related taxes that do not meet the requirements of § 433.68 and any health care-related taxes in excess of the limits specified in paragraph (a)(1) of this section.

§ 433.72 Waiver provisions applicable to health care-related taxes.

(a) *Bases for requesting waiver.* (1) A State may submit to HCFA a request for a waiver if a health care-related tax does not meet any or all of the following:

(i) The tax does not meet the broad based criteria specified in § 433.68c); and/or

(ii) The tax is not imposed uniformly but meets the criteria specified in § 433.68(d)(2) or (d)(3).

(2) When a tax that meets the criteria specified in paragraph (a)(1) of this section is imposed on more than one class of health care items or services, a separate waiver must be obtained for each class of health care items and services subject to the tax.

(b) *Waiver conditions.* In order for HCFA to approve a waiver request that would permit a State to receive tax revenue (within specified limitations) without a reduction in FFP, the State must demonstrate, to HCFA's satisfaction, that its tax program meets all of the following requirements:

(1) The net impact of the tax and any payments made to the provider by the State under the Medicaid program is generally redistributive, as described in § 433.68(e);

(2) The amount of the tax is not directly correlated to Medicaid payments; and

(3) The tax program does not fall within the hold harmless provisions specified in § 433.68(f).

(c) *Effective Date.* A waiver will be effective:

(1) The later of January 1, 1992, or the date of enactment of the tax for programs in existence prior to October 1, 1992; or

(2) For tax programs commencing on or after October 1, 1992, on the first day in the quarter in which the waiver is received by HCFA.

§ 433.74 Reporting requirements.

(a) Beginning with the first quarter of Federal fiscal year 1993, each State must submit to HCFA quarterly summary information on the source and use of all provider-related donations (including all bona fide and presumed-to-be bona fide donations) received by the State or unit of local government, and health care-related taxes collected. Each State must also provide any additional information requested by the Secretary related to any other donations made by, or any taxes imposed on, health care providers. States' reports must present a complete, accurate, and full disclosure of all of their donation and tax programs and expenditures.

(b) Each State must provide the summary information specified in paragraph (a) of this section on a quarterly basis in accordance with procedures established by HCFA.

(c) Each State must maintain, in readily reviewable form, supporting documentation that provides a detailed description and legal basis for each donation and tax program being reported, as well as the source and use of all donations received and taxes collected. This information must be made available to Federal reviewers upon request.

(d) If a State fails to comply with the reporting requirements contained in this section, future grant awards will be reduced by the amount of FFP HCFA estimates is attributable to the sums raised by tax and donation programs as to which the State has not reported properly, until such time as the State complies with the reporting requirements. Deferrals and/or disallowances of equivalent amounts may also be imposed with respect to quarters for which the State has failed to report properly. Unless otherwise prohibited by law, FFP for those expenditures will be released when the State complies with all reporting requirements.

B. Part 447 is amended as follows:

PART 447—PAYMENTS FOR SERVICES

1. The authority citation for part 447 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 447.272(c) is revised to read as follows:

§ 447.272 Application of upper payment limits.

* * * * *

(c) *Disproportionate share.* The upper payment limitation established under paragraphs (a) and (b) of this section does not apply to payment adjustments made under a State plan to hospitals found to serve a disproportionate number of low-income patients with special needs as provided in § 447.253(b)(1)(ii)(A). The payment limitations for aggregate State disproportionate share hospital payments are specified in §§ 447.296 through 447.299. States must submit a separate upper payment limit assurance that its aggregate disproportionate share hospital payments do not exceed the disproportionate share hospital payment limits.

3. A new subpart E, consisting of §§ 447.296 through 447.299, is added to read as follows:

Subpart E—Payment Adjustments for Hospitals That Serve a Disproportionate Number of Low-Income Patients

Sec.

Sec.
447.298 State disproportionate share hospital allotments.
447.299 Reporting requirements.

§ 447.296 Limitations on aggregate payments for disproportionate share hospitals for the period January 1, 1992 through September 30, 1992.

(a) The provisions of this section apply to the 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act.

(b) For the period January 1, 1992 through September 30, 1992, FFP is available for aggregate payments to hospitals that serve a disproprotionate number of low-income patients with special needs only if the payments are made in accordance with sections 1902(a)(13)(A) and 1923 of the Act, and with one of the following:

(1) An approved State plan in effect as of September 30, 1991.

(2) A State plan amendment submitted to HCFA by September 30, 1991.

(3) A State plan amendment, or modification thereof, submitted to HCFA between October 1, 1991 and November 26, 1991, if the amendment, or modification thereof, was intended to limit the State's definition of disproportionate share hospitals to those hospitals with Medicaid inpatient utilization rates or low-income utilization rates (as defined in section 1923 (b) of the Act) at or above the statewide arithmetic mean.

(4) A methodology for disproportionate share hospital payments that was established and in effect as of September 30, 1991, or in accordance with a State law enacted or State regulation adopted as of September 30, 1991.

(5) A State plan amendment submitted to HCFA by September 30, 1992 that increases aggregate disproportionate share hospitals payments in order to meet the minimum payment adjustments required by section 1923(c)(1) of the Act. The minimum payment adjustment is the amount required by the Medicare methodology described in section 1923(c)(1) of the Act for those hospitals that satisfy the minimum Federal definition of a disproportionate share hospital in section 1923(b) of the Act.

(6) A State plan amendment submitted to HCFA by September 30, 1992 that provides for a redistribution of disproportionate share hospital payments within the State without raising total payments compared to the previously approved State plan. HCFA will approve the amendment only if the State submits written documentation that demonstrates to HCFA that the aggregate payments that will be made after the redistribution are no greater than those payments made before the redistribution.

(7) A State plan amendment submitted to HCFA by September 30, 1992 that provides for a reduction in disproportionate share hospital payments.

§ 447.297 Limitations on aggregate payments for disproportionate share hospitals beginning October 1, 1992.

(a) *Applicability.* The provisions of this section apply to the 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act.

(b) *National payment limit.* The national payment limit for disproportionate share hospital payments for any Federal fiscal year is equal to 12 percent of the total medical assistance expenditures that will be made during the Federal fiscal year under State plans, excluding administrative costs. Preliminary expenditure projections will be made by HCFA prior to October 1 of each year. These preliminary expenditures will be revised as specified in paragraph (d) of this section.

(c) *State payment limits.* At the end of each calendar year, a reconciliation will be made to actual expenditures. HCFA will calculate the final actual DSH national 12 percent expenditure limit based on the data available as of December 31 following the end of the Federal fiscal year for which the calculation is made. HCFA will publish these final allotments in the **Federal Register** by the following April 1. For Federal fiscal years beginning on or after October 1, 1992, FFP is available for payments made by a State to hospitals that serve a disproportionate number of low-number patients with special needs if the aggregate disproportionate share hospital payments do not exceed the State's disproportionate share hospital allotment, as specified in § 447.298. Preliminary allotments will be made by HCFA prior to October 1 of each year. These preliminary allotments will be revised as specified in paragraph (d) of this section.

(d) *Revisions of preliminary projections.* HCFA will revise the preliminary national expenditure estimates and the preliminary State DSH allotments at two points in the Federal fiscal year.

(1) HCFA will advise the State Medicaid Directors by April 1 of each year of updated national limits and updated State DSH allotments. This April update will be based on the February Medicaid budget submissions as reviewed and adjusted, if necessary, by HCFA.

(2) Based on the information available as of December 31 of each year, attributable to the prior Federal fiscal year for which the limit is being calculated, HCFA will calculate the final DSH national 12 percent expenditure limit and the final individual State DSH allotments. These amounts will be published in the **Federal Register** by the following April 1. These final limit projections will be calculated as follows:

(i) For the first year, Federal fiscal year 1993, the final limit projections will reflect a reconciliation of the estimated State disproportionate share expenditures for Federal fiscal year 1992, estimated total State Medicaid expenditures and national expenditures to actual amounts.

(ii) For subsequent years (Federal fiscal year 1994 and later), a reconciliation will be made of the estimated total State Medicaid expenditures and the national expenditures to actual.

(iii) If HCFA determines that a State has exceeded its final DSH allotment, the excess expenditures will be disallowed.

(e) *Publication of limits.* (1) Before the beginning of each Federal fiscal year, HCFA will publish in the **Federal Register**—

(i) A preliminary national disproportionate share hospital payment limit for the Federal fiscal year; and

(ii) A preliminary disproportionate share hospital allotment for each State for the Federal fiscal year.

(2) Beginning in 1994, by April 1 of each year, HCFA will publish in the **Federal Register** final national disproportionate share hospital and State allotment projections for the prior Federal fiscal year, as described in paragraph (d) of this section.

§ 447.298 State disproportionate share hospital allotments.

(a) *Calculation of State's base allotment for Federal fiscal year 1993.* (1) For Federal fiscal year 1993, HCFA will calculate for each State a disproportionate share hospital allotment, using the State's "base allotment." The State's base allotment is the greater of:

(i) The total amount of the State's projected disproportionate share hospital payments for Federal fiscal year 1992 under the State plan during Federal fiscal year 1992, calculated in

accordance with paragraph (a)(2) of this section; or

(ii) $1,000,000.

(2) In calculating the State's disproportionate share hospital payments during Federal fiscal year 1992, HCFA will derive amounts from payments made for the period of October 1, 1991 through September 30, 1992 under State plans or plan amendments that meet the requirements specified in § 447.296(b). The calculation will not include—

(i) Disproportionate share hospital payment adjustments made by the State for the period October 1, 1991 through December 31, 1991 under State plans or plan amendments that do not meet the criteria described in § 447.296; and

(ii) Retroactive DSH payments made in 1992 that are not applicable to Federal fiscal year 1992.

(3) HCFA will calculate a percentage for each State by dividing the disproportionate share hospital base allotment by the total medical assistance expenditures, excluding administrative costs, projected to be made during Federal fiscal year 1992. On the basis of this percentage amount, HCFA will classify each State as a "high-DSH" or "low-DSH" State.

(i) If the State's base allotment exceeded 12 percent of its total medical assistance expenditures projected to be made under the State plan in Federal fiscal year 1992, HCFA will classify the State as a "high-DSH" State.

(ii) If the State's base allotment was 12 percent or less of its total medical assistance expenditures projected to be made under the State plan in Federal fiscal year 1992, HCFA will classify the State as a "low-DSH" State.

(b) *State disproportionate share hospital allotments for Federal fiscal year 1993.* (1) For Federal fiscal year 1993, HCFA will calculate a disproportionate share hospital allotment for each low-DSH State that equals the State's base allotment described under paragraph (a) of this section, increased by—

(i) State growth, as specified in paragraph (d) of this section; and

(ii) A State supplemental amount as described in paragraph (e) of this section.

(2) For high-DSH States, the dollar amount of disproportionate share hospital payments in Federal fiscal year 1993 may not exceed the dollar amount of payments made in Federal fiscal year 1992.

(c) *State disproportionate share hospital allotment for Federal fiscal years 1994 and after.* For Federal fiscal years 1994 and after—

(1) For low-DSH States, HCFA will calculate the allotment for each Federal fiscal year by increasing the prior year's State disproportionate share hospital allotment by—

(i) State growth, as specified in paragraph (d) of this section; and

(ii) A supplemental amount as described in paragraph (e) of this section.

(2) For high-DSH States, the dollar amount of disproportionate share hospital payments in any Federal fiscal year may not exceed the dollar amount of payments made in Federal fiscal year 1992. This payment limitation will apply until the Federal fiscal year in which the State's disproportionate share hospital payments, expressed as a percentage of the State's total medical assistance expenditures, equal 12 percent or less. When a high-DSH State's percentage of total medical assistance expenditures equals 12 percent or less, the State will be reclassified as a low-DSH State.

(d) *State growth.* (1) The State growth for a State in a Federal fiscal year is equal to the product of—

(i) The growth factor that is HCFA's projected percentage increase in the State's total medical assistance expenditures (including administrative costs) relative to the corresponding amount in the previous year; and

(ii) The State's prior year disproportionate share hospital allotment.

(2) If the growth factor is zero, the State growth is zero.

(3) If the growth factor is negative, the State growth is negative and results in a reduced DSH allotment compared to the State's prior year's disproportionate share hospital allotment.

(e) *Supplemental amount available for low-DSH States.*

(1) A supplemental amount is the State's share of a pool of money (referred to as a redistribution pool).

(2) HCFA will calculate the redistribution pool for the appropriate Federal fiscal year by subtracting from the projected national disproportionate share hospital limit the following:

(i) The total of the State base allotment for all high-DSH States;

(ii) The total of the previous year's State disproportionate share hospital allotments for all low-DSH States (or in the case of Federal fiscal year 1993, the total of State base allotments);

(iii) The State growth for all low-DSH States; and

(iv) The total amount of disproportionate share hospital payment adjustments made in order to meet the minimum payment adjustments required under section 1923(c)(1) of the Act, which are made in accordance with § 447.296(b)(5).

(3) HCFA will determine the percent of the redistribution pool for each low-DSH State on the basis of the State's relative share of total medical assistance expenditures compared to the total medical assistance expenditures projected to be made by the low-DSH States. The percent of the redistribution pool that each State will receive is equal to the State's medical assistance expenditures divided by the total medical assistance expenditures for all low-DSH States.

(4) HCFA will not provide any low-DSH State a supplemental amount that would result in the State's disproportionate share hospital allotment exceeding 12 percent of its projected medical assistance expenditures. HCFA will reallocate any amounts not allocated to States because of this 12 percent limitation to other low-DSH States in accordance with their share of medical assistance expenditures. HCFA will not reallocate to low-DSH States the difference between any State's actual disproportionate share hospital payment and its base allotment.

(f) *Special provision.* Any increases in a State's aggregate disproportionate payments, that are made to meet the minimum payment requirements specified in § 447.296(b)(5), may exceed the State base allotment to the extent such increases are made to satisfy the minimum payment requirement. In such cases, HCFA will adjust the State's base allotment in the subsequent Federal fiscal year to include the increased minimum payments.

(g) *National limit adjustment.* In the event the aggregate amount of the State DSH allotments for any Federal fiscal year, beginning October 1, 1992, exceeds 12 percent of the total amount of medical assistance expenditures (excluding administrative costs) projected by HCFA to be made during that fiscal year, each State's DSH allotment, as determined under this section, will be reduced proportionally to ensure that the 12 percent cap is not exceeded.

§ 447.299 Reporting requirements.

(a) Beginning with the first quarter of Federal fiscal year 1993, each State must submit to HCFA the quarterly aggregate amount of its disproportionate share hospital payments made to each individual public and private provider or facility. States' reports must present a complete, accurate, and full disclosure of all of their DSH programs and expenditures.

(b) Each State must report the aggregate information specified under paragraph (a) of this section on a quarterly basis in accordance with procedures established by HCFA.

(c) Each State must maintain, in readily reviewable form, supporting documentation that provides a detailed description of each DSH program, the legal basis of each DSH program, and the amount of DSH payments made to each individual public and private provider or facility each quarter. This information must be made available to Federal reviewers upon request.

(d) If a State fails to comply with the reporting requirements contained in this section, future grant awards will be reduced by the amount of FFP HCFA estimates is attributable to the expenditures made to the disproportionate share hospitals as to which the State has not reported properly, until such time as the State complies with the reporting requirements. Deferrals and/or disallowances of equivalent amounts may also be imposed with respect to quarters for which the State has failed to report properly. Unless otherwise prohibited by law, FFP for those expenditures will be released when the State complies with all reporting requirements.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: November 19, 1992.

William Toby,

Acting Deputy Administrator, Health Care Financing Administration.

Approved: November 20, 1992.

Louis W. Sullivan,

Secretary.

[FR Doc. 92-28621 Filed 11-20-92; 4:35 pm]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 90

[DA 92-1491]

Licensing of Channels in the 896-901/935-940 MHz and 220-222 MHz Bands in the U.S./Mexico Border Area

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This Order modifies Part 90 to permit private land mobile entities to apply for licenses to operate radio systems on channels in the 896-901/935-940 MHz and 220-222 MHz bands within 110 km (68.4 miles) and 120 km (74.6 miles), respectively, of the Mexican border. Prior to adoption of these rules, lengthy and complex coordination procedures were required before these frequencies could be used in the Mexico border area. Even then, access was not guaranteed. With these new rules, radio users will have greater and faster access to these channels and will likely have fewer restrictions on their use.

EFFECTIVE DATE: November 24, 1992.

FOR FURTHER INFORMATION CONTACT: Edward R. Jacobs, Land Mobile and Microwave Division, Private Radio Bureau, 202-632-7597.

SUPPLEMENTARY INFORMATION: On July 24, 1986, the Commission allocated ten megahertz of spectrum in the 896-901 MHz and 935-940 MHz bands for use in the Private Land Mobile Radio Services. The Commission subsequently issued a Public Notice on November 4, 1986, that established filing procedures for this private land mobile spectrum. In that Public Notice, the filing of applications for channels in the Business and Industrial/Land Transportation pools was restricted to systems to be located at least 68.4 miles (110 kilometers) from the United States/Mexico border. Although the Commission accepted applications for channels in the SMR pool in the Mexican border area, it stated that no license grants would be made for applications in border areas pending further discussion with Mexico. On March 14, 1991, the Commission adopted a Report and Order establishing service rules to provide for the use of the 220-222 MHz band by private land mobile radio services. In a subsequent Memorandum Opinion and Order, adopted June 18, 1992, the Commission further noted that use of the 220-222 MHz frequencies in the Mexican border areas will be subject to coordination with Mexico. The conclusion of Agreements with Mexico on the 900 MHz and 220 MHz bands constitutes the coordination envisioned in these rule makings and now opens the way for licensing of private land mobile radio stations in the Mexico border area.

List of Subjects in 47 CFR Part 90

Land Mobile, Mexico, Radio.

Beverly G. Baker,

Deputy Chief, Private Radio Bureau.

Rule Changes

Part 90 of chapter 1 of title 47 of the Code of Federal Regulations is amended as follows:

PART 90—PRIVATE LAND MOBILE RADIO SERVICES

1. The authority citation for part 90 continues to read as follows:

Authority: Sections 4, 303, 48 Stat., 1066, 1082, as amended; 47 U.S.C. 154, 303, and 332, unless otherwise noted.

2. Section 90.555 is amended by amending paragraph (b) to add the frequency bands 896-901 MHz and 935-940 MHz to the Combined Frequency List numerically to read as follows:

§ 90.555 Combined Frequency Listing.

* * * * *

(b) Combined frequency list

Frequency	Services	Special limitations
*	*	*
MEGAHERTZ		
896 to 901	All Svcs	Mobile.
*	*	*
935 to 940	All Svcs	Base or Mobile.
*	*	*

3. Section 90.619 is amended by revising the introductory text of paragraphs (a), (a)(2), (a)(3), (a)(4), and (a)(5), by revising the heading of Table 1C, by redesignating Table 2 as Table 2A and revising the heading, by redesignating Table 3 as Table 3A and revising the heading, by redesignating Table 4 as Table 4A and revising the heading, and by adding new Tables 2B, 3B and 4B to paragraphs (a)(3), (a)(4), and (a)(5) respectively, to read as follows:

§ 90.619 Frequencies available for use in the U.S./Mexico and U.S./Canada border areas.

(a) U.S./Mexico border area. The channels listed in Tables 1A, 2A, 3A and 4A are offset 12.5 kHz lower in frequency than those specified in the 806-821/851-866 MHz Table in § 90.613. The Channel 201 base frequency will be 856.000 MHz, followed by Channel 202 at 856.025 MHz and proceeding with uniform 25 kHz channeling to Channel 400 at 860.975 MHz. Mobile station frequencies will be 45 MHz lower in frequency. These channels are available for assignment for conventional or trunked systems only in areas 110 kilometers (68.4 miles) or less from the U.S./Mexico border. Stations located on Mt. Lemmon, serving the Tucson, AZ area, will only be authorized offset frequencies. The channels listed in Tables 2B, 3B, and 4B correspond to those specified in the 896-901/935-940 MHz Table in § 90.613 and are not offset. Mobile station frequencies will be 39 MHz lower in frequency. The frequencies listed in Tables 2B, 3B, and

4B are not available for licensing in the U.S./Mexico border area until June 11, 1993.

* * * * *

(2) Certain channels in the 821–824/866–869 MHz band are also available to eligible applicants in the Public Safety Category in areas within 110 kilometers (68.4 miles) of the U.S./Mexico border. These channels will be assigned according to the policies defined in the Report and Order of Gen. Docket No. 87–112 (See §§ 90.16 and 90.34). The following channels are available only for mutual aid purposes as defined in Gen. Docket No. 87–112: channels 601, 639, 677, 715, and 753. Certain channels in the 896–901/935–940 MHz band are also available in areas within 110 kilometers (68.4 miles) of the U.S./Mexico border. The specific channels that are available for licensing in the bands 821–824/866–869 and 896–901/935–940 MHz within 110 kilometers (68.4 miles) of the Mexico border are listed in Tables 1B, 2B, 3B, and 4B and are subject to Effective Radiated Power (ERP) and Antenna Height limitations as indicated in Table 1C. In addition, all channels designated for use within Mexico in the 821–824/866–869 MHz and 896–901/935–940 MHz bands are available for assignment to U.S. stations within 110 kilometers (68.4 miles) of the Mexico border if the maximum power flux density (pfd) of the station's transmitted signal at any point at or beyond the border does not exceed −107 dB(W/m^2). The spreading loss must be calculated using the free space formula taking into account any antenna discrimination in the direction of the border. Authorizations for stations using channels allotted to Mexico on a primary basis will be secondary to Mexican operations and conditioned to require that licensees take immediate action to eliminate any harmful interference resulting from the station's transmitted signal exceeding −107 dB(W/m^2).

* * * * *

Table 1C—Limits of Effective Radiated Power (ERP) Corresponding to Antenna Heights of Base Stations in the 821–824/866–869 MHZ and 896–901/935–940 MHZ Bands within 110 Kilometers (68.4 miles) of the Mexican Border

* * * * *

(a)(3) Tables 2A and 2B list the channels that are available for assignment to eligible applicants in the Industrial/Land Transportation Category, (consisting of the Power, Petroleum, Forest Products, Video Production, Relay Press, Special Industrial, Manufacturers, Telephone Maintenance, Motor Carrier, Railroad, Taxicab and Automobile Emergency Radio Services). Specialized Mobile Radio Systems (SMRS) will not be authorized in this category except as indicated in § 90.621(g).

Table 2A—United States/Mexico Border Area, Industrial/Land Transportation Category 806–821/851–866 MHZ Band (60 Channels):

* * * * *

Table 2B—United States/Mexico Border Area, Industrial/Land Transportation Category 896–901/935–940 MHZ Band (99 Channels):

For multichannel systems, channels may be grouped vertically or horizontally as they appear in the table. Channels numbered above 200 may be used only subject to the power flux density limits stated in paragraph (a)(2) of this section:

Channel Nos.

31–32–33–34–35
36–37–38–39–40
71–72–73–74–75
76–77–78–79–80
111–112–113–114–115
116–117–118–119–120
151–152–153–154–155
156–157–158–159–160
191–192–193–194–195
196–197–198–199–200
231–232–233–234–235
236–237–238–239–240
271–272–273–274–275
276–277–278–279–280
311–312–313–314–315
316–317–318–319–320
351–352–353–354–355
356–357–358–359–360
391–392–393–394–395
396–397–398–399

(a)(4) Tables 3A and 3B list the channels that are available for assignment to eligible applicants in the Business Radio Category. This category does not include Specialized Mobile Radio Systems as defined in § 90.603(c). These channels are available for inter-category sharing as indicated in § 90.621(g).

Table 3A—United States/Mexico Border Area, Business Category 806–821/851–866 MHZ Bands (60 Channels)

* * * * *

Table 3B—United States/Mexico Border Area, Business Category 896–901/935–940 MHz Band (100 Channels):

For multichannel systems, channels may be grouped vertically or horizontally as they appear in the table. Channels numbered above 200 may be used only subject to the power flux density limits stated in paragraph (a)(2) of this section.

Channel Nos.

11–12–13–14–15
16–17–18–19–20
51–52–53–54–55
56–57–58–59–60
91–92–93–94–95
96–97–98–99–100
131–132–133–134–135
136–137–138–139–140
171–172–173–174–175
176–177–178–179–180
211–212–213–214–215
216–217–218–219–220
251–252–253–254–255
256–257–258–259–260
291–292–293–294–295
296–297–298–299–300
331–332–333–334–335
336–337–338–339–340
371–372–373–374–375
376–377–378–379–380

(a)(5) Tables 4A and 4B list the channels that are available for assignment for the SMRS Category (consisting of Specialized Mobile Radio Systems (SMRS) as defined in § 90.603(c)). These channels are available for inter-category sharing as indicated in § 90.621(g).

Table 4A—United States/Mexico Border Area, SMRS Category 806–821/851–866 MHz Band (95 Channels):

* * * * *

Table 4B—United States/Mexico Border Area, SMR Category 896–901/935–940 MHz BAND (200 CHANNELS):

Channels numbered above 200 may be used only subject to the power flux density limits at or beyond the Mexican border stated in paragraph (a)(2) of this section:

Group No.	Channel Nos.
1	1–2–3–4–5–6–7–8–9–10.
21	21–22–23–24–25–26–27–28–29–30.
41	41–42–43–44–45–46–47–48–49–50.
61	61–62–63–64–65–66–67–68–69–70.
81	81–82–83–84–85–86–87–88–89–90.
101	101–102–103–104–105–106–107–108–109–110.
121	121–122–123–124–125–126–127–128–129–130.
141	141–142–143–144–145–146–147–148–149–150.
161	161–162–163–164–165–166–167–168–169–170.
181	181–182–183–184–185–186–187–188–189–190.
201	201–202–203–204–205–206–207–208–209–210.

Group No.	Channel Nos.
221	221-222-223-224-225-226-227-228-229-230.
241	241-242-243-244-245-246-247-248-249-250.
261	261-262-263-264-265-266-267-268-269-270.
281	281-282-283-284-285-286-287-288-289-290.
301	301-302-303-304-305-306-307-308-309-310.
321	321-322-323-324-325-326-327-328-329-330.
341	341-342-343-344-345-346-347-348-349-350.
361	361-362-363-364-365-366-367-368-369-370.
381	381-382-383-384-385-386-387-388-389-390-.

* * * * *

4. Section 90.715 is amended by adding a sentence to the end of the introductory text of paragraph (a) and adding a new paragraph (c) to read as follows:

§ 90.715 Frequencies available.

(a) * * * Use of these frequencies in the Mexican and Canadian border areas is subject to coordination with those countries. See paragraph (c) of this section for special provisions concerning use in the Mexico border area.

* * * * *

(c) U.S./Mexico border area.

(1) Channels 16–30, 45–60, 76–90, 106–120, 136–145, 156–165, 178–194 are available for primary use within the United States within 120 km (74.6 mi) of the Mexican border, subject to the power and antenna height conditions specified in § 90.729 and the use restrictions specified in §§ 90.717–90.721.

(2) Channels 195–200 are available to both the United States and Mexico in the border area on an unprotected basis. Use is limited to a maximum effective radiated power (ERP) of 2 watts and a maximum antenna height of 6.1 meters (20 ft) above ground.

(3) Channels allotted for primary Mexican use (1–15, 31–45, 61–75, 91–105, 121–135, 146–155, and 166–177) may be used in the border area subject to the condition that the power flux density not exceed -86 dB(W/m^2) at or beyond any point on the border. Stations operating under this provision will be considered secondary and will not be granted protection from harmful interference from stations that have primary use of the frequencies.

[FR Doc. 92-27748 Filed 11-23-92; 8:45 am]

BILLING CODE 6712-01-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 652

[Docket No. 900124-0127]

Atlantic Surf Clam and Ocean Quahog Fishery

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Suspension of surf clam minimum size limit.

SUMMARY: NMFS notifies the public that the minimum size limit of 4.75 inches (12.065 cm) for Atlantic surf clams is suspended for the 1993 fishing year. This action is taken under the authority of regulations that allow for the annual suspension of minimum size limit based upon set criteria. The intended effect is to reduce regulatory burden while allowing for more selective harvest practices.

EFFECTIVE DATE: January 1, 1993, through December 31, 1993.

FOR FURTHER INFORMATION CONTACT: Myles Raizin, Resource Policy Analyst, National Marine Fisheries Service, One Blackburn Drive, Gloucester, MA 01930 (508–281–9104).

SUPPLEMENTARY INFORMATION: A final rule implementing Amendment 8 to the Fishery Management Plan for the Atlantic Surf Clam and Ocean Quahog Fishery (FMP) was published on June 14, 1990 (55 FR 24184). Section 652.22(a)(1) allows the Director, Northeast Region, NMFS, (Regional Director) to suspend annually, by publication in the **Federal Register**, the minimum size limit for Atlantic surf clams. This action may be taken unless discard, catch, and survey data indicate that 30 percent of the clams are smaller than 4.75 inches (12.065 cm) and that the overall reduced size is not attributable to beds where growth of the individual clams has been reduced because of density dependent factors.

At its September meeting, the Mid-Atlantic Fishery Management Council accepted the recommendations of its Scientific and Statistical Committee and Surf Clam/Ocean Quahog Committee and voted to recommend that the Regional Director suspend the minimum size limit. NMFS port agents conducted a random sample of landed surf clams in 1992. Results indicate that only 7 percent of the sample was composed of clams that were less than 4.75 inches (12.065 cm). Therefore, this action is consistent with the provisions of § 652.22(a)(1).

Classification

This action is authorized by 50 CFR part 652, and is taken in compliance with E.O. 12291.

Authority: 16 U.S.C. 1081 *et seq.*

List of Subjects in 50 CFR Part 652

Fisheries, Reporting and recordkeeping requirements.

Dated: November 18, 1992.

Richard H. Schaefer,

Director of Office of Fisheries, Conservation and Management, National Marine Fisheries Service.

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National Oceanic and Atmospheric Administration (NOAA)

50 CFR Parts 672 and 675

[Docket No. 921198-2298]

Groundfish of the Gulf of Alaska; Groundfish of the Bering Sea and Aleutian Islands Area

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Final rule; technical amendment.

SUMMARY: NMFS announces a technical amendment to a final rule implementing measures to facilitate the enforcement of fishery closures for Alaska groundfish that was published September 23, 1992 (57 FR 43926). This technical amendment clarifies NMFS' intent with respect to deployment of specified gear types in an area when directed fishing for all groundfish species by operators of vessels using that gear type is prohibited. This action also corrects a numbering error in the regulatory text of the final rule. This technical amendment is consistent with the goals and objectives of the final rule.

EFFECTIVE DATE: Effective November 23, 1992.

FOR FURTHER INFORMATION CONTACT: Susan J. Salveson, Fisheries Management Division, Alaska Region, NMFS, 907–586–7228.

SUPPLEMENTARY INFORMATION: A final rule published September 23, 1992 (57 FR 43926), revised 50 CFR 672.7 and 675.7 to establish management measures that facilitate the enforcement of directed fishing closures that are implemented when either directed fishing allowances or prohibited species bycatch allowances are reached. Sections 672.7(g) and 675.7(h) were added to the final rule so that when directed fishing in an area for all groundfish species by